PRINTED: 10/07/2016 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C 08/25/2016	
NAME OF D	ROVIDER OR SUPPLIER	040023	1		TREET ADDRESS, CITY, STATE, ZIP CODE	1 08/	25/2016
NAIVIE OF PI	ROVIDER OR SUPPLIER						
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH			201 CLARKS FORK DRIVE		
				R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD I		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY A INDIVIDUALITY	ND RESPECT OF	F2	241			9/22/16
	manner and in an env	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.					
	by: Based on record revi interview, the facility a wait to be fed in the a other residents were l 26, # 94 & # 81) of 3 s during a lunch meal. 1. Resident #26 was a 8/16/10 with multiple Dementia. The quart (MDS) assessment da Resident #26 had me problems and needed eating. The care plan for Res The care plan for nutr approaches to assist intake routinely and fo assisted feeding room On 8/24/16 at 12:20 F observed in the assist	allowed residents to sit and ssisted dining room while being fed for 3 (Residents # sampled residents observed Findings included: admitted to the facility on diagnoses including erly Minimum Data Set ated 6/24/16 indicated that mory and decision making I extensive assistance with sident #26 was reviewed. Fittion dated 6/14/16 included the resident with meal or the resident to eat in the			This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plar correction does not constitute an admission or agreement by the provide the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. This p of correction is prepared and submitted solely because of requirements under state and federal law and to demonstrathe good faith attempt by the provider to improve the quality of life of our resider. Corrective action will be accomplished the resident found to have been affected by the deficient practice: Resident #26 is receiving assistance we meals in a timely manner. Resident #81 no longer in the facility.	er of lolan te o ots. for	
	resident on the same a family member.	at this time. There was a table who was being fed by PM, there were 12 residents			Corrective action will be accomplished those residents having potential to be affected by the same deficient practice		
APOBATORY	DIPECTOR'S OF PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	-		TITI F		(X6) DATE

09/19/2016

Electronically Signed Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDII	' '		, ا	2
		345529	B. WING _				25/2016
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
LININ/EDO	AL LIEALTH CADE/NOD	TH DATEION		52	201 CLARKS FORK DRIVE		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		R	ALEIGH, NC 27616		
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F 241	F 241 Continued From page 1		F 2	F 241			
	nurse's aides (NA). (was able to feed self fed by a family mem				All residents have the potential to be affected. 100% audit of all active residents		
	fed by a family member. One nurse aide was observed feeding one resident at a time while other residents were waiting to be fed. At 12:40 PM, 3 additional staff members came to the assisted dining room to help feed the residents.				completed on 09/15/2016 by Dietary Manager to determine the assistance required during meals and dining room designation for all three meals. Finding	s	
		PM, NA #2 was interviewed. NAs were scheduled to the			documented on "Dining Designation At tool.	ıdit"	
	assisted dining room every meal. There were eleven residents in the assisted dining room that needed to be fed. The residents had to wait to get fed.				Measures put into place or systemic changes made to ensure that the defic practice will not re-occur:	ent	
		PM, NA#2 was observed to			Moving forward, three tables in the madining room will be designated effective 9/19/2016 for residents who requires assistance with feeding.		
	interviewed. The Ad NAs in the assisted of	M, the Administrator was ministrator indicated that the dining room should be at a time but they were not.			Nursing assistance will be feeding two residents at a time, effective 9/12/2016	i.	
	She also stated that to be fed in a timely	she expected the residents manner.			Trays will be delivered to one table at a time effective 9/19/2016.	l	
					The Director of Nursing, Assistant Director of Nursing, nursing supervisor		
	4/23/15 with multiple	admitted to the facility on diagnoses including The quarterly Minimum			and/or Corporate Quality Assurance & Performance Improvement Director completed 100% education of all curre		
	Data Set (MDS) asset indicated that Reside	essment dated 6/8/16 ent #94 had memory and			nursing staff, to include full time, part ti and as needed employees. This	me	
	decision making prol assistance with eatin	plems and needed extensive ng.			education will be completed by 9/22/20 This education will cover facility new dining processes to include; assisting	16.	
	•	sident #94 dated 6/8/16 e resident with eating.			residents on one table at a time, feedir two residents on the same table at one		
					time and ensure all residents are fed in	ا د	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _		ns	C 3/25/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		720/2010	
				5201 CLARKS FORK DRIVE			
UNIVERSA	AL HEALTH CARE/N	ORTH RALEIGH		RALEIGH, NC 27616			
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F 241	Continued From p	page 2 20 PM, Resident #94 was	F 2	41 timely manner. Any nursing	staff not		
	observed in the as lunch tray in front member feeding h	of him. There was no staff nim at this time. Other residents were being fed by staff		educated by 9/22/2016 will not owork until educated. This taught annually and added to orientation packet. Monitoring Process	not be allowed education will		
	in the assisted dir (NA). One of the ten feed self and one family member. Of feeding one residents were water additional staff medining room to help to the feed of the feed on 8/24/16 at 12: NA #2 stated that assisted dining roeleven residents in needed to be feed. On 8/24/16 at 1:0.	25 PM, there were 12 residents hing room with 3 nurse's aides welve residents was able to resident was being fed by a ne nurse aide was observed ent at a time while other hiting to be fed. At 12:40 PM, 3 embers came to the assisted p feed the residents. 45 PM, NA #2 was interviewed. 3 NAs were scheduled to the om every meal. There were in the assisted dining room that The residents had to wait to get		The Director of Nursing, Ass Director of Nursing, Nurse surpriector of Social Services, I manager, and/or Facility Admonitor dining rooms for one 4 weeks, then one meal monthly substantial compliance is mathree consecutive months. To monitoring is to ensure reside timely, one table is served at qualified employees will feed residents at one time. Any nuffindings identified during the process will be corrected promonitoring will be documented from monitoring tool.	upervisor, Dietary ministrator will e meal daily x ekly x 4 weeks until eintained for his lents are fed t a time and d two egative monitoring omptly. This ed on dining		
	interviewed. The NAs in the assiste feeding 2 resident She also stated the befed in a time. 3. Resident #81 w 6/11/16 with multi Hypertension. The (MDS) assessment.	5 PM, the Administrator was Administrator indicated that the ed dining room should be es at a time but they were not. eat she expected the residents		The Director of Nursing will r of the dining room monitoring the Quality Assurance and P Improvement Committee mo three months or until a patter compliance is achieved for the consecutive months.	g process to Performance onthly for rn of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED			
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	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616	1 33/25/23 13
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F 241	eating. The care plan for Re indicated to assist the On 8/24/16 at 12:20 observed in the assist lunch tray in front of member feeding him in the dining room we members. On 8/24/16 at 12:25 in the assisted dining (NA). One of the twe feed self and one restamily member. One feeding one resident residents were waitin additional staff member dining room to help for the compact of	sident #81 dated 6/11/16 e resident with eating. PM, Resident #81 was sted dining room with his him. There was no staff at this time. Other residents ere being fed by staff PM, there were 12 residents groom with 3 nurse's aides live residents was able to sident was being fed by a nurse aide was observed at a time while other ag to be fed. At 12:40 PM, 3 pers came to the assisted eed the residents. PM, NA #2 was interviewed. NAs were scheduled to the every meal. There were an eassisted dining room that the residents had to wait to get end. When the dining room should be at a time but they were not she expected the residents.	F 24	41	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NITIMBED:		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER		1	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00/	23/2010
				5201	CLARKS FORK DRIVE		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		RAL	EIGH, NC 27616		
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F 242 SS=D	MAKE CHOICES The resident has the	TERMINATION - RIGHT TO right to choose activities,	F 2	242			9/22/16
	her interests, assess interact with member inside and outside th	h care consistent with his or ments, and plans of care; so of the community both e facility; and make choices or her life in the facility that resident.					
	by: Based on staff interview the factor of review the factor of schoice to ambulate residents able to ambulate (Resident #22). The Resident #22 was accumulative diagnose neuropathy, osteoarthistory of falls. The most recent Minassessment an annuresident was moderate could walk with limited the MDS also reveal in the corridor only of	lmitted 8/14/14 with			This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plathis plan of correction does not constitute an admission or agreement by the provider of the truth of the facts allege the correctness of the conclusions set forth on the statement of deficiencies. Plan of correction is prepared and submitted solely because of requirement and the state and federal law, and to demonstrate the good faith attempts be the provider to improve the quality of light each resident.	ute d or The ent y ife	
	care and was unstea stabilize with human Review of the Restor Physical Therapy dat following instruction to pt (patient) to ambu	dy when walking but could		f a i	for the resident found to have been affected by the deficient practice: Resident #22 receives ambulation assistance per preference by a restoratide or assigned nursing assistant effective 09/19/2016.		

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					201 CLARKS FORK DRIVE			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH			ALEIGH, NC 27616			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 242	Continued From pag	ge 5	F 2	242				
	assist) (with) wc (wh	eelchair) follow and use of			Corrective action will be accomplished	for		
	RW (rolling walker).	Pt should have back brace			those residents having potential to be			
	and (illegible). "				affected by the same deficient practice	:		
		rative Roster for Resident			100% choices and preferences audit			
		ugh 8/25/16 revealed alked 50 feet over a duration			completed by the Director of Social Services on 09/15/2016 & 09/16/2016	to		
		otal of 8 days in June, 7 days			determine each residents choices and	10		
		August (16 days total).			preferences, specifically in relation to			
		eceived other restorative			walking. Non-interview able resident's			
		age of motion, splint or brace			choices and preferences were done by			
		sfer assistance on the 16			interviewing power of attorney and or			
		restorative staff during this			guardian. Findings of this audit are			
		ll as on 15 additional days			documented on "Resident Choices Aud	dit		
	during this period (6/	/1/16 - 8/25/16).			tool".			
		PM Nursing Assistant #5 (NA			On 9/15/16, 9/16/16 and 9/19/16, a 10			
	# 5) was interviewed				audit for all residents who are currently			
	_	Aids (RA) provided walking			restorative nursing program re-screene			
		sidents who needed to have			by a Licensed Therapist to ensure that			
		ing. She stated that the NA '			each resident receives appropriate			
		do it. She also indicated			modalities with frequency and duration	as		
		e Aids were not available were assisted with walking by			determined by the screening.			
		would not receive assistance			Measures put into place or systematic			
	with walking on thos				changes made to ensure that the defic	ient		
		- · · · , - ·			practice will not re-occur:			
	On 8/25/16 at 2:03 F	PM RA #1 was interviewed.						
		ere were two RA 's that			Moving forward all current nursing			
	usually worked but if	they got pulled from			assistants will be responsible to honor			
		work on the hall as Nursing			resident's choices of walking when			
		dents did not receive the			requested during their shift and as			
		cated on their Restorative			appropriate, effective 09/19/2016.			
		lking. She added that there						
		eximately 30 residents on the			Resident choices and preferences to			
		d and that she and the other			include choices for walking will be			
	Restorative Aide spli				assessed on admission/readmission,			
		sidents each. RA #1 stated			quarterly and with significant changes			
	mat it was up to the	RA to determine which of			"Choices and Preference tool" by Direct	, LOI		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _				C 25/2016
	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616			
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F 242	their residents to provide days they were a there was no set scheaddition she said that get to everyone on the of them had been pull further indicated that restorative care was or other residents on and that the Nursing provide restorative cawalking when the RAOn 8/25/15 at 2:30 P Administrator revealer residents received as were physically able they wanted to walk what is assistance to walk dahelp him maintain his that on some days he walk but that he was	vide restorative care to on ssigned to restorative as edule for the residents. In a sometimes they could not e caseload, especially if one led to work on the hall. She if they were both pulled not offered to Resident #22 the caseload those days Assistants on the hall did not are such as assistance with 's were not available. M interview with the ed it was her expectation that esistance to walk daily if they to walk with assistance and with assistance on a daily M Resident #22 was ed that he did want to receive hilly as he thought it would a ability to walk. He added e was offered assistance to not offered walking added that he had not	F2		of Social Services or Activities Director Effective 9/22/16. Any choices and preferences identified by the tool will be implemented as indicated. 100% education of residents rights and include choices and preferences education involving all staff will be completed by 9/22/16 by the Director of Nursing, Assistant Director of Nursing and/or Director of Social Services. Any staff not educated by 9/22/16 will not be allowed to work until completed. This is included in the new hire orientation pace and will be done annually. Monitoring Process: Effective on 9/22/16, Activity Director of Administrator will review the completion "Choices and Preference tool" daily (More 4 weeks, then weekly for 4 weeks at then monthly until substantial compliant is maintained for three months. Effective on 9/22/16, 'resident appointed ambassador' will monitor daily (Monday through Friday) to ensure residents choices and preference are implemented per "Choices and Preference Tool". A dresident appointed ambassador' is a department manager who is assigned the set of residents to monitor and follow unwith that resident as a point of contact. They will document their rounds on the dambassador Round Tool.' The Director of Social Services will reparadit findings to the Quality Assurance	e I to If I e Is cket I r In of I -F) Ind Ince I ed I to a I p	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 242	Continued From page	e 7	F 24	and Performance Improvement Committee monthly for three month until a pattern of compliance is achi	
F 244 SS=E	must listen to the view grievances and recornand families concerni	MMENDATION mily group exists, the facility	F 24		9/22/16
	by: Based on record revinterview, the facility of that were brought in the promptly. Findings in The facility's policy or grievances/complaint. The policy indicated the complaints may be suresident or the person complaint on behalf of also be verbalized to be responsible for do grievance/concern or Upon receipt of a writh complaint, the approprintersigate the allegate report of such finding 72 hours of receiving complaint. The admininterdisciplinary teams the person investigate.	in filing s, undated, was reviewed. hat a grievance and or ubmitted in writing by the in filing the grievance or if the resident. They may any staff member, who will cumenting the in the appropriate form. Item grievance and or oriate designee will tions and submit a written is to the administrator within ithe grievance and or inistrator and the will review the findings with		This plan of correction constitutes a written allegation of compliance. Preparation and submission of this correction does not constitute an admission or agreement by the provide the truth of the facts alleged or the correctness of the conclusions set from the statement of deficiencies. The of correction is prepared and submissolely because of requirements und state and federal law and to demon the good faith attempt by the providing improve the quality of life of our resentate. Corrective Action will be accomplish the resident found to have been affectly the deficient practice: Grievances about staffing and call the responses identified on resident's continuous constitutions.	plan of vider of orth ois plan tted ler strate er to idents. ned for ected

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345529	B. WING				25/2016
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(X4) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 244	Continued From page	e 8	F	244			
	· -	ent or person filing the		_ ' '	minutes on 4/19/2016, 5/24/2016,		
		nplaint on behalf of the			6/21/2016 and 6/28/2016 resolved,		
	_	med of the findings of the			resident receiving assistance with ADL		
		actions that will be taken to			and call bell responses resolved. On		
	_	problems. Such report will			9/20/16, the concerns were resolved by	/	
	· ·	e administrator or his or her			following up with the resident council to		
		orking days of the filing of the			ensure no further issues with these are		
	grievance or complai	nt with the facility.					
	The resident council	minutes for the last 6			Corrective Action will be accomplished	for	
	months (March-Augu	st) were reviewed. The			those residents having potential to be		
	minutes dated 4/19/1				affected by the same deficient practice	:	
		sed issues on getting help in				_	
		nurse aides saying " I'll be			All residents have potential to be affect	ed.	
	_	d not return. The minutes			4000/ gudit for all regident's council		
		ed that the residents stated			100% audit for all resident's council	. d	
	_	etting assistance in a timely ssue. The minutes dated			minutes in the last 12 months complete on 09/20/2016 by the administrator to	eu	
		t residents continued to			identify any other repeated grievance the	hat	
		taff answering call lights and			may warrant any follow up. Any finding		
		back and would not come			be implemented promptly.	•••••	
		call light and would not			are impromented promptly.		
		utes dated 6/28/16 indicated			Findings of the audit included 9		
	that several residents	s had complained that NAs			occurrences within the last year of call	bell	
	would answer the cal	I lights and said they will be			concerns, and 6 occurrences of staffing	9	
	right back but would i	not return. The minutes			concerns.		
		ed that the issue of NAs					
		g off the light and said that			Measures put in place or systematic		
		but not returning was still			changes made to ensure that the defici	ent	
		es dated 8/16/16 indicated			practice will not re-occur		
		that the concern with staff			4000/ 1 // 6 // 1 / 6 // 1		
		g off the lights and saying			100% education of all staff will be done	-	
	that someone is com				the Director of Social Services, Director		
		AM, Resident #67, the ent council, was interviewed.			Nursing and Regional Clinical Director the grievance process from resident	UII	
	-	that the concerns with short			council and the buildings process		
		he call lights timely, and staff			beginning with receiving concerns to		
		ere repeatedly brought up in			following up with a resolution to the		
	the meeting. Reside				appropriate party. This education will b	e	
		erns had not been resolved.			completed by 09/22/2016, any staff not		

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F 244	F 244 Continued From page 9		F 2	244				
	was interviewed. Th responsible in setting meeting. The AD inc	M, the Activity Director (AD) e AD stated that she was g up the resident council dicated that when a resident			educated by 09/22/2016 will not be allowed to work until educated. The Director of Nursing, Assistant			
	had a concern that w	as brought up in the form was completed and			Director of Nursing and Regional Clinic Director will conduct an education for a			
		Administrator. The AD			staff, all departments, to include full tim			
		ne same issues with short			part time and as needed staff, in relation			
		the call light timely, turning off beatedly brought up in the			to call bell response. Education to inclustaff responsibilities for answering call	ide		
	meeting.	boatedly brought up in the			lights timely and to not turn off call light	t		
	0/05/40 4 0 05 514				until residents needs are met. This			
	· ·	the Administrator was ministrator stated that she			education will be completed by 09/22/2016, any staff not educated by			
		ues from the resident council			09/22/2016 will not be allowed to work			
		en in-serviced on answering			until educated.			
	that she was new to and she had not don	The administrator also stated the facility as administrator e any audit or monitoring yet of call lights timely or staff			Effectively 09/22/2016; The administrativill review resident council grievances within seventy-two hours of the report. The resident council president will recefollow-up from the investigation as well corrective action recommended within working days of grievances filed.	ive as		
					Monitoring Process: The Administrator, Department Manage Nursing Supervisor, and/or Manager of Duty will monitor all grievances in relatito call bell responses, staffing or turnin off call bell before care is rendered dail (Monday through Friday) for four weeks weekly for four weeks, then monthly for three months afterwards or until the pattern of compliance is maintained. The Administrator or Director of Social	n ion g y s,		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345529	B. WING _				C / 25/2016
	ROVIDER OR SUPPLIER	H RALEIGH	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616		01 CLARKS FORK DRIVE	1 00/	23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 244	Continued From page	÷ 10	F2	244	Services will follow-up with resident council president weekly x4 weeks, the monthly x3 months to ensure grievand have been resolved.		
F 272 SS=D	483.20(b)(1) COMPR ASSESSMENTS	EHENSIVE	F 2	272			9/22/16
	a comprehensive, accreproducible assessment functional capacity. A facility must make a assessment of a resident assessment by the State. The assleast the following: Identification and den Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior p Psychosocial well-bei Physical functioning a Continence; Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sur the additional assess areas triggered by the Data Set (MDS); and	a comprehensive dent's needs, using the instrument (RAI) specified sessment must include at mographic information; atterns; ng; and structural problems; d health conditions; status;					

OLIVILIY	O I OIT MEDIO/ IITE A	WEDIO/ ND OLIVIOLO				O 1110	7. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BOILD			,	С
		345529	B. WING			l	25/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HNIVERS	AL HEALTH CARE/NOR	TH RAI FIGH		52	201 CLARKS FORK DRIVE		
ONIVERO	AL HEALTH OAKE/NOK	MALLION		R	ALEIGH, NC 27616		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX TAG	· '	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 272	Continued From page	e 11	F	272			
	by:	Γ is not met as evidenced					
		ecord review and staff			This plan of correction constitutes a		
	assess three of twen	/ failed to comprehensively			written allegation of compliance. Preparation and submission of this plar	n of	
	I .	Area Assessment (CAA), not			this plan of correction does not constitu		
		t and not doing the resident			an admission or agreement by the		
	interview for customa	ary and routine activities on			provider of the truth of the facts alleged	l or	
		assessments for Resident			the correctness of the conclusions set		
	#166, #88 and #96.	The findings included:			forth on the statement of deficiencies.	Γhe	
					plan of correction is prepared and		
		as admitted to the facility			submitted solely because of requireme	nt	
		ed on 5/28/16 (hospitalized			under state and federal law, and to		
		Cumulative diagnoses ateral femoral hernia without			demonstrate the good faith attempts by the provider to improve the quality of lif		
	obstruction hypertens				of each resident.	C	
	dysphagia (difficulty				or each resident.		
		ch), thyroid disorder, gout			Corrective Action will be accomplished	for	
	' '	t behavioral disturbance.			the resident found to have been affected by the deficient practice:		
	An Admission Minimu	um Data Set (MDS) dated			,		
		dent was rarely/ never			Resident #166 Care Area Assessment	for	
	I .	erview indicated resident			urinary incontinence for MDS assessm	ent	
	had short term and lo				dated 4/7/2016 was completed by MDS	3	
	1	nt #166 required extensive			Nurse #1 on 9/15/16 .		
		ig. Resident #166 was			Resident #96 is no longer in the facility		
	_	ent of bladder and freq.			No further action needed for this reside		
	incontinent of bowel.				Resident #88 is no longer in the facility		
	A manda f. H. O.	A A			No further action needed for this reside	nt.	
	I .	Area Assessment (CAA) for			Corrective Action will be accountible a	for	
	unnary status reveale	ed the CAA was blank.			Corrective Action will be accomplished those residents having potential to be	Ю	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 501251	_		، ا	С	
		345529	B. WING				25/2016	
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				5	201 CLARKS FORK DRIVE			
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		R	ALEIGH, NC 27616			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE	
F 272	Continued From page	e 12	F	272				
	On 8/25/2016 at 10:4	6 AM, an interview was			affected by the same deficient practice	:		
	conducted with the M	IDS Coordinator who stated						
	-	y but the CAA's were not			All residents have the potential to be			
		ere was a time when she			affected.			
	_	theck the CAA's and the			4000/ 17 6			
		k. She stated she believed			100% audit of most recent comprehens			
		ch. She stated IT (computer snotified about the blank			MDS assessment to ensure Care Area			
	,	d there was not a problem			Assessments were completed when triggered was done by MDS Nurse #1	and		
		ne stated she now checks to	#2 on 9/15/16, 9/16/16, and 9/19/16.		ilu			
	make sure the CAA's are completed.							
		•			The results of the audit indicated 4 other	er		
	On 08/25/2016 at 3:1	8 PM, an interview was			comprehensive assessments with miss	ing		
	conducted with the A	dministrator who stated she			care area assessments. Assessments			
		be accurate and complete			were modified to indicate appropriate			
	per the clinical record				completion of the care area assessmen	ıt.		
		admitted on 4/4/16 with			4000/			
	multiple diagnoses th sclerosis.	iat included multiple			100% audit of most recent comprehens MDS assessment Section F to ensure	sive		
	SCIE10313.				interview for customary routine and			
	A nursing note dated	4/11/16 indicated Resident			activities was conducted per RAI			
	_	ented and was able to make			Guidelines by MDS Nurse #1 and #2 o	n		
	her needs known to s				9/15/16, 9/16/16, 9/19/16. This audit			
					included reviewing question B700 to			
	A social service note	dated 4/11/16 indicated			ensure interview to ensure customary			
		ert and verbal, she was able			routine and activities was done if indica	ited		
		nown, and she was able to			for section F.			
	make daily decisions	•						
	The Admission Minim	num Data Sat (MDS)			The results of the audit indicated 4 other	er :		
	The Admission Minim	dent #96 dated 4/11/16			Section F's were not documented			
	indicated she had mo				appropriately.			
		e hearing, clear speech, was			100% audit of most recent resident			
		nd understood others.			assessment to ensure height is coded	in		
	-	ences for Customary and			question K0200A was done by Certified			
	Routine Activities Sec	ction, indicated the resident			Dietary Manager on 9/15/16. Any findir	ngs		
		d activity preferences was			will be addressed per RAI guidelines a	3		
	not conducted becau				indicated.			
	rarely/never understo	ood. There were no answers	1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45500				1	С	
		345529	B. WING _			08/	25/2016	
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		52	201 CLARKS FORK DRIVE			
0111121107	12 112/12/11 0/11/2/11/01/			R	ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 272	Continued From pag	ge 13	F 2	272				
	indicated for the rem	nainder of the resident			The results of the audit indicated that a	all		
	interview for daily an	nd activity preferences			heights were documented appropriatel	y.		
	_	rough F0500). The staff				•		
	assessment of daily			Measures put into place or systematic				
	completed for Reside	ent #96.			changes made to ensure that the defic	ient		
					practice will not re-occur:			
	An interview was cor	nducted with the						
		5/16 at 2:53 PM. She			Moving forward, the facility will utilize			
	-	ation was for the MDS to be			Resident Interview Wizard in licensed			
		ed on the resident's medical			electronic health record software to			
	record.				complete indicated resident interviews			
					include residents for customary routine	<i>;</i>		
		nducted with the MDS			and activities.			
		/16 at 3:00 PM. The 4/11/16			1000/ advection of all ourrent pursing			
		essment for Resident #96 ne MDS Coordinator. She			100% education of all current nursing staff, to include full time, part time and	our		
		nt interview for daily and			as needed nursing staff, will be comple			
		should have been conducted.			by Director or Nursing, Assistant Director			
	activity preferences	should have been conducted.			of Nursing and/or RN supervisor on	toi		
	3. Resident # 88 was	s admitted to the facility on			09/15/2016, 09/16/2016, and 09/19/20	16		
		e diagnoses including End			on obtaining height and on height entry			
		e (ESRD) and was on			into licensed electronic health record	,		
	•	Admission Minimum Data Set			software on admission and annually.			
		dated 7/1/16 indicated that			Education on obtaining vitals to include	3		
		ition was intact and she had			height will be included in the new hire			
	received dialysis whi	ile a resident at the facility.			orientation packet and will be done			
	The assessment und	der the area of height was not			annually.			
	completed with dash	nes on the box.						
					The MDS nurse #1 and #2, Certified		[
	An interview was con	nducted with the			Dietary Manager, Director of Social			
		5/16 at 2:53 PM. She			Services and Activities Director were			
		ation was for the MDS to be			educated by Regional Clinical Director			
		ed on the resident's medical			9/19/16, regarding completing the Care			
	record.				Area Assessment and accuracy of MD		[
					completion according to RAI guidelines	3 .		
		PM, the MDS Coordinator was						
		DS Coordinator stated that			Monitoring Process:			
	•	ve been entered on the MDS			Eff. 1: 00/40/0043 :			
assessment and not dashes.		dashes.			Effective 09/19/2016, prior to submissi	on		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C 08/25/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	1 00/2	.5/2010
				5201 CLARKS FORK DRIVE			
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
F 272	Continued From page	÷ 14	F2	Director of Social Serve Director, and/or Certificial will review all comprehessessments completed #2 to ensure all Care Assession completed will be comprehensive assess 50% of all completed completed will completed will completed will be completed will complete will complete will complete will revie will revie will revie will revie will completed will be seen will be weeks, then 25% of assessments monthly until compliance is ach weeks, then 25% of assessments monthly until compliance is ach will revie will revie comprehensive assess by Activities Director to for customary routine as	ed Dietary Managensive ed by MDS Nurse Area Assessment ered in Section Naments not pleted prior to e place Monday eeks on 100% ements complete comprehensive or 4 weeks, then comprehensive for 3 months or nieved. Drior to submission Nurse #2 ling off on the w 100% complete tuestion K0200) for esments, 50% of esments weekly for all completed MD for 3 months or nieved. Drior to submission weekly for all completed MD for 3 months or nieved. Drior to submission for 3 months or nieved. Drior to submission micro to submission for 3 months or nieved. Drior to submission micro to sub	e its //. d, on, ted for ice all all or OS	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245520	B WING			С	
		345529	B. WING_			08/	25/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	H RAI FIGH		52	201 CLARKS FORK DRIVE		
				R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278 SS=D	483.20(g) - (j) ASSES ACCURACY/COORD The assessment mus resident's status. A registered nurse museach assessment with participation of health A registered nurse musessment is complete.	SSMENT PINATION/CERTIFIED It accurately reflect the ust conduct or coordinate in the appropriate professionals. ust sign and certify that the eted. completes a portion of the in and certify the accuracy of		272	completed per RAI guidelines. Any interviews not completed will be completed prior to submission. These reviews will take place Monday through Friday for 4 weeks on 100% comprehensive assessments complete 50% of all completed comprehensive assessments weekly for 4 weeks, then 25% of all completed comprehensive assessments monthly for 3 months or until compliance is achieved. MDS Nurse #1, MDS Nurse #2, Direct of Social Services, Activities Director, and/or Certified Dietary Manager will present the findings of this audit, effect 9/22/2016, to the Quality Assurance at Performance Improvement Committee monthly for three months or until patter of compliance is achieved.	or ive nd n	9/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			08/25/2016	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	00/20/2010	
				5201 CLARKS FORK DRIVE			
UNIVERSA	AL HEALTH CARE/NO	RTH RALEIGH		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 278	willfully and knowin false statement in a subject to a civil mo \$1,000 for each ass willfully and knowin to certify a material resident assessment penalty of not more assessment. Clinical disagreeme material and false so the control of the contr	and Medicaid, an individual who agly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who and false statement in a and false statement in a and is subject to a civil money at than \$5,000 for each and the statement. NT is not met as evidenced a statement.	F 2	This plan of correction conswritten allegation of complia Preparation and submission this plan of correction does an admission or agreement provider of the truth of the fathe correctness of the conclusion for the statement of definition plan of correction is prepare submitted solely because of under state and federal law, demonstrate the good faith at the provider to improve the of each resident. Corrective action will be accurate the resident found to have be by the deficient practice: 1. Resident # 1 1a. Minimum Data Set dated	of this plan of the constitute by the acts alleged or usions set ficiencies. The d and requirement and to attempts by quality of life omplished for een affected		
	Resident #1 was fo	llowed by hospice care.		modified/corrected by MDS	Nurse #1 on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			1			С		
		345529	B. WING _		0	8/25/2016		
NAME OF P	ROVIDER OR SUPPLIER	1	1	STREET ADDRESS, CITY, STATE, ZIP COL		0.1_0.1_0		
				5201 CLARKS FORK DRIVE				
UNIVERSA	AL HEALTH CARE/NO	ORTH RALEIGH		RALEIGH, NC 27616				
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)		
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETION DATE		
F 278	Continued From p	age 17	F 2	278				
				08/24/2016 to indicate in Que	estion J1400			
	The admission Mir	nimum Data Set (MDS) dated		that resident had life expecta	ncy of 6			
	7/29/16 indicated	Resident #1 was cognitively		months.				
	intact. Section J,	the Health Conditions section,		1b. Minimum Data Set dated	7/29/16 was			
		Resident #1 had a life		modified by MDS Nurse #1 o	n 08/24/2016			
		months or less (Question		to indicate in Question O010				
	J1400).			modified to indicate resident				
				receiving Hospice services w				
		edical record revealed hospice		resident and while a resident				
	progress notes da Resident #1.	ted 7/22/16 through 8/23/16 for		1c. Minimum Data Set dated				
	Resident#1.			modified/corrected by MDS N 08/24/2016 to indicate in Que				
	Δn interview with I	Resident #1 was conducted on		O0100L modified to indicate				
		Virevealed she had received		admitted for respite services				
		prior to her admission through		resident.				
	present (8/23/16).	Ğ		1d. Minimum data Set dated	7/29/16 was			
	, , ,			modified/corrected by MDS N	Nurse #1 on			
	An interview was	conducted with the		08/24/2016 to indicate in Sec	ction I, to			
		the MDS Coordinator on		include anxiety as an active of	-			
		M. Both the Administrator and		1e. Minimum Data Set dated				
		indicated Resident #1 was not		modified/corrected by MDS N				
	•	nospice progress notes, dated		08/24/2016 to indicate in Que	•			
		/23/16, for Resident #1 that		that resident had no natural t	eeth.			
		e hard copy medical record h the Administrator and MDS		2. Resident #112a. Minimum Data Set dated	7/12/16 was			
		Administrator indicated she		modified/corrected by MDS N				
		ip with the hospice provider to		09/17/2016 to indicate in que				
		t #1 was on hospice services.		the correct number of days o				
		thir trace on neophed convided.		antipsychotic medications in				
	An interview was	conducted with the facility Nurse		back period.	- , - ,			
		e Administrator on 8/24/16 at		2b. Minimum Data Set dated	7/13/16 was			
	10:45 AM. The fa	cility Nurse Consultant		modified/corrected by MDS N				
		pice provider confirmed		09/17/2016 to indicate in Sec	ction I, the			
		eceived hospice services prior		correct active diagnosis.				
		continued to receives services		3. Resident #96 is no longe	r at the			
	, , ,	8/24/16). He revealed the MDS		facility.				
	was coded inaccu	rately for life expectancy.		4. Resident #72				
				4a. Minimum Data Set dated				
	∣ A follow up intervie	ew was conducted with the		modified/corrected by MDS N	lurse #1 on			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C 08/25/2016	
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP C 5201 CLARKS FORK DRIVE RALEIGH, NC 27616	•	00/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 278	indicated her expect coded accurately barecord. 1b. A nursing note d Resident #1 was foll The admission Minir 7/29/16 indicated Reintact. Section O, th Procedures, and Procedures, and Procedures #1 had not not a resident (Ques received hospice ca O0100K2).	4/16 at 5:39 PM. She ation was for the MDS to be sed on the resident's medical ated 7/22/16 indicated owed by hospice care. num Data Set (MDS) dated esident #1 was cognitively be Special Treatments, ograms section, indicated received hospice care while ation O0100K1) and had not re while a resident (Question	F 2	278 09/17/2016 to indicate in q the correct number of days received. 5. Resident #103 is no lor facility. Corrective actions will be a for those residents having affected by the same deficited. All residents have potentian 100% of current residents by Director of Social Service determine if they are received services and Respite Services.	accomplished potential to be ient practice: I to be affected. will be audited ces to ving Hospice rices.		
	A review of the medical record revealed a hospice progress notes dated 7/22/16 through 8/23/16 for Resident #1. An interview with Resident #1 was conducted on 8/23/16 at 4:45 PM revealed she had received hospice services prior to her admission through present (8/23/16). An interview was conducted with the Administrator and the MDS Coordinator on 8/24/16 at 9:50 AM. Both the Administrator and MDS Coordinator indicated Resident #1 was not on hospice. The hospice progress notes, dated 7/22/16 through 8/23/16, for Resident #1 that were located in the hard copy medical record were reviewed with the Administrator and MDS Coordinator. The Administrator indicated she needed to follow up with the hospice provider to confirm if Resident #1 was on hospice services. An interview was conducted with the facility Nurse			other residents were hospi services. 1a. 100% of residents on howere audited by MDS Nurs 09/16/2016, 09/17/16 and accuracy on Question J14 Modifications/corrections of Minimum Data Set as indic guidelines. The results of the audit independents currently on hospicorrectly under Question J15. 100% of residents on howere audited by MDS Nur on 09/16/2016, 09/17/16 a for accuracy in Question O1 Hospice Care while not a rowhile a resident. Modificati done to Minimum Data Set	nospice services se #1 and #2 on 09/18/2016 for 100, Prognosis. Ione to cated per RAI licated that all pice were coded 1400. nospice services se #1 and #2 nd 09/18/2016 100100K, resident and ons/corrections		

Facility ID: 20040007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345529	B. WING _			08	3/25/2016	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
LININ/EDO	NI LIEALTH CADE (N	ORTH RALEIOU		52	01 CLARKS FORK DRIVE			
UNIVERSA	AL HEALTH CARE/N	ORTH RALEIGH		R/	ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 278	Continued From p	page 19	E 2	278				
1 270	· ·	-	F 2	2/0	nor DAI suidelines			
		e Administrator on 8/24/16 at cility Nurse Consultant			per RAI guidelines. The results of the audit indicated that	all		
		pice provider confirmed			residents currently on hospice were co			
		eceived hospice services prior			correctly under Question O0100K.			
		continued to receives services						
	. • • •	3/24/16). He revealed the MDS			1c. 100% audit of residents on respite			
		rately for hospice care while not			care were conducted by MDS Nurse #	! 1		
	a resident and ho	spice care while a resident.			and #2 on 09/16/16, 09/17/16, and 09/18/16 to ensure that all residents			
	Δ follow up intervi	ew was conducted with the			admitted for respite care were coded			
	•	8/24/16 at 5:39 PM. She			accurately in Question O0100L, Respi	ite		
		ectation was for the MDS to be			Care. Modifications/corrections done t			
		based on the resident's medical			Minimum Data Set as indicated per RA			
	record.				guidelines. At the time of audit no			
					residents were currently on respite car	re.		
	1c. A nursing note	e dated 7/22/16 indicated			1d. 100% audit of all active resident's			
	Resident #1 was a	admitted to the facility for respite			most recent MDS assessment was			
	care.				conducted by MDS Nurse #1 and #2 c 09/16/2016, 09/17/16 and 09/18/2016			
		edical record revealed a hospice			ensure all active diagnoses were code			
	· •	ed 7/22/16 for Resident #1 that			appropriately in section I, Oral/Dental			
	indicated she was	at the facility for a respite stay.			status in question L0200 and number	of		
	The admission M	DS dated 7/29/16 indicated			days resident received antipsychotic	^		
		cognitively intact. Section O,			medication and antibiotic therapy in the seven day look back period on question			
		nents, Procedures, and			N0410A and N0410F consecutively pe			
		, indicated Resident #1 had not			RAI guideline. The audit will also inclu			
		are while a resident at the			rejection of care coding in question EC			
	facility (Question (as per RAI guideline.			
					Modifications/corrections done to			
		Resident #1 was conducted on			Minimum Data Set as indicated per RA	٩I		
		M revealed she was admitted to			guidelines.			
	•	2/16 for a respite stay. She			The pative diagraphic soullt for C. C.			
		s had changed and she was			The active diagnosis audit for Section	I		
	now long term car	€.			revealed 9 other assessments were coded incorrectly.			
	An interview was	conducted with the			The audit of Question L0200 revealed	no		
		the MDS Coordinator on			other coding errors.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_			С	
		345529	B. WING				25/2016	
NAME OF P	ROVIDER OR SUPPLIER	•	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	,		
				52	201 CLARKS FORK DRIVE			
UNIVERSA	AL HEALTH CARE/NOR	IH RALEIGH		R	ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 278	Continued From pag 8/24/16 at 9:50 AM. MDS Coordinator inc Resident #1 was addrespite stay. The nur/22/16, for Resident admitted for a respite Administrator and MI Administrator indicate the issue to determin admitted to the facilit Coordinator indicated section the question located. An interview was cor Consultant and the A 10:45 AM. The facili indicated Resident #7/22/16 for a respite was coded inaccurated. A follow up interview Administrator on 8/24 indicated her expecta coded accurately bas record.	Both the Administrator and licated they had not known if nitted to the facility for a resing progress note, dated #1 that indicated she was e stay was reviewed with the DS Coordinator. The ed she needed to look into e if Resident #1 was y for respite care. The MDS d she had not known what about respite care was administrator on 8/24/16 at ty Nurse Consultant 1 was admitted to the facility stay. He revealed the MDS ely respite care. was conducted with the #1/16 at 5:39 PM. She ation was for the MDS to be sed on the resident #1 dated onazepam (antianxiety		278		ent 6. 2 0 d nt.		
	The July 2016 Medic	ation Administration Record ident #1 was administered			Monitoring Process: Effective 09/19/2016, prior to submission Director of Social Services and/or Activities Director will review completed MDS Assessment by MDS Nurse #1 or	d		
	Resident #1 was cog	dated 7/29/16 indicated initively intact. Section I, the ction, was not coded for 700).			MDS Nurse #2 to ensure Question J14 Question O0100K, Question O0100L, Section I, Question LO200, Question N0410, and Question E0800 are codes			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343323		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	08/25/2016	
NAME OF PI	ROVIDER OR SUPPLIER			, , ,	=		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE			
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDESICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 278	8/24/16 at 9:50 AM. section of Resident # was reviewed with the Coordinator. Anxiety active diagnosis for F admission MDS. The 7/22/16 for PRN Clorreviewed with the Adi Coordinator. The Jul Resident #1 was admonce during the look admission MDS was Administrator and ME Coordinator indicated diagnosis of anxiety f 7/29/16 MDS look bawas coded incorrectly anxiety as active diagnosis of anxiety dindicated her expectated accurately bas record. 1e. A nursing note da Resident #1 had no record. The admission MDS Resident #1 was cog Oral/Dental Status se had no dental issues.	aducted with the e MDS Coordinator on The Active Diagnoses 1's 7/29/16 admission MDS and Administrator and MDS are was not indicated as an Resident #1 on the 7/29/16 aphysician's order dated an azepam for anxiety was ministrator and MDS are y 2016 MAR that indicated ministered PRN Clonazepam back period of the 7/29/16 reviewed with the DS Coordinator. The MDS at there was an active for Resident #1 during the ck. She revealed the MDS and should have indicated gnosis for Resident #1. Was conducted with the MDS to be seed on the resident's medical and the Area of the MDS to be seed on the resident's medical and the Area of 1/29/16 indicated matural teeth. In MDS dated 7/29/16 indicated matural teeth. In MDS dated 7/29/16 indicated mitively intact. Section L, the action, indicated Resident #1	F 27		y through bleted MDS bleted MDS bleted MDS bleted MDS bleks, then bees ments compliance submission, urse #2 on the bleted MDS on E0800 is bleted MDS all weekly for bleted MDS on the bleted MDS	f	
		sident #1 was conducted on Resident #1 stated she had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345529	B. WING			C 8/25/2016		
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CO. 5201 CLARKS FORK DRIVE RALEIGH, NC 27616		0/23/2010		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 278	8/23/16 at 4:46 PM r natural teeth. An interview was cor Administrator and Mi 9:50 AM. The Oral/I Resident #1's 7/29/1 reviewed with the Ad Coordinator. The nuthat indicated Reside was reviewed with the Coordinator. The resident #1 and the observati 8/23/16 that indicate was reviewed with the Coordinator. The Mi 7/29/16 MDS for Resinaccurately and sho no natural teeth. A follow up interview Administrator on 8/2 indicated her expects coded accurately bas record.	esident #1 was conducted on evealed Resident #1 had no inducted with the DS Coordinator on 8/24/16 at Dental Status section of 6 admission MDS was ministrator and MDS ursing note dated 7/22/16 ent #1 had no natural teeth e Administrator and MDS sident interview with Resident on of Resident #1 from d she had no natural teeth e Administrator and MDS DS Coordinator indicated the	F 2					
	multiple diagnoses the depressive disorder, dementia with behave 2a. A physician 's or 1/29/16 indicated Se	nat included major anxiety disorder, and						
	The annual MDS dat	ed 7/13/16 indicated						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C 08/2/	5/2016
	ROVIDER OR SUPPLIER	'H RALEIGH		STREET ADDRESS, CITY 5201 CLARKS FORK D RALEIGH, NC 27610	DRIVE	1 00/23	5/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COI	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Resident #11 had mo She was indicated to medications on 0 of 7 MDS look back period (MAR) for Resident # administered Seroque 7/13/16 MDS look back An interview was con Administrator on 8/24 indicated her expectate coded accurately bas record. An interview was con Coordinator on 8/25/10 Coordinator reviewed Resident #11. She in inaccurately for antips 2b. A physician's order Cymbalta (antidepresidally. A pharmacy consultational indicated Resident #1 anxiety and major departments of the physician's progress indicated Resident #1 depression. A physician's note day	derate cognitive impairment. have received antipsychotic days during the 7/13/16 d. ation Administration Record 11 indicated she was el on 7 of 7 days during the ck period. ducted with the /16 at 5:39 PM. She tion was for the MDS to be ed on the resident's medical ducted with the MDS to be ed on the resident's medical ducted with the MDS to be ed on the resident's medical ducted with the MDS to be ed on the resident's medical dicated the MDS was coded sychotic medications. er for Resident #11 indicated sant medication) 60mg tion note dated 5/26/16 the received Cymbalta for pressive disorder. Is note dated 5/30/16 the day of t	F2	7.78			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C 08/25/2016	
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616		00/23/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 278		ation note dated 6/28/16	F 2	78			
	anxiety and major de						
	Resident #11 had m and she received an 7 of 7 days during th	ted 7/13/16 indicated oderate cognitive impairment tidepressant medications on the MDS look back period. Indicated as an active					
	indicated her expect	nducted with the 4/16 at 5:39 PM. She ation was for the MDS to be sed on the resident's medical					
	Coordinator on 8/25 Coordinator reviewe	nducted with the MDS /16 at 3:00 PM. The MDS d the 7/13/16 annual MDS for ndicated the MDS was coded we diagnoses.					
		admitted on 4/4/16 with hat included multiple					
		d 4/11/16 indicated Resident riented and was able to make staff.					
	Resident #96 was al	e dated 4/11/16 indicated ert and verbal, she was able known, and she was able to s.					
	4/11/16 indicated sh	for Resident #96 dated e had moderate cognitive te hearing, clear speech, was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C 08/25/2016	
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS 5201 CLARKS FO RALEIGH, NC 2		1 00,	20/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 278	Section F, the Prefe Routine Activities se interview was not co #96 was rarely/never F0300). An interview was co Administrator on 8/2 indicated her expect coded accurately barecord. An interview was co Coordinator on 8/25 admission MDS ass was reviewed with thindicated Question Fincorrectly on Resid MDS. 4. Resident #72 wa 2/12/13 and readmit diagnoses included: disease, diabetes, disturbance and urin A Quarterly Minimur 7/25/16 indicated Reimpaired in cognition	and understood others. rences for Customary and retion, indicated the resident anducted because Resident re understood (Question Inducted with the 14/16 at 5:39 PM. She ration was for the MDS to be sed on the resident's medical Inducted with the MDS 16 at 3:00 PM. The 4/11/16 Inducted with the MDS Inducte	F 2	278	DEFICIENCY)		
	Record (MAR) for the through 7/25/16 reversantibiotic (Cipro) on On 8/25/16 at 3:14P						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5201 CLARKS FORK DRIVE RALEIGH, NC 27616)8/25/2016 	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 278	having been received On 8/25/16 at 3:15F conducted with the A expected the MDS t per the clinical recoive 5. Resident #103 w 8/28/12 and dischar Cumulative diagnos cerebrovascular acc loss of function) on mellitus, multiple join artery disease, hype pulmonary disease, reflux and chronic ki A Quarterly Minimur 3/16/16 indicated Re intact. Moods noted nearly every day. N A review of the bath #103 for the look ba (3/10/16 through 3/1 3/12/16 resisted car resisted carenurse On 8/25/16 at 11:12 conducted with Nurs stated he remember usually provided car evenings. He stated	ny antibiotics was coded as ed for seven days. PM, an interview was Administrator who stated she to be accurate and complete rd. Pass admitted to the facility ged to the hospital 3/28/26. The included, in part, beident with hemiplegia (partial the dominant side, diabetes and contractures, coronary tertension, chronic obstructive hypothyroidism, esophageal idney disease. PM Data Set (MDS) dated desident #103 was cognitively defeling tired, no energy to behaviors were noted. Preport roster for Resident tack period for behaviors ternurse notified; 3/16/16 anotified. AM, an interview was sing Assistant (NA) #1. He red Resident #103 and the for Resident #103 in the defension in	F 2	, , , , , , , , , , , , , , , , , , ,			
	evening shift twice a showers the majority	e his showers during the a week and refused the y of the time. NA#1 stated d refuse to have a bed bath at stated when it was					

A. BUILDING COMPLETED C	ME OE DROVINED OD SLIDDI IED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	ME OF PROVIDED OR SLIPPLIED
UNIVERSAL HEALTH CARE/NORTH RALEIGH 5201 CLARKS FORK DRIVE RALEIGH, NC 27616	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	REFIX (EACH DEFICIENT
F 278 Continued From page 27 documented "resisted care", it meant Resident #103 refused care. On 8/25/2016 at 3:16PM, an interview was conducted with the MDS Coordinator who stated she reviewed the nursing notes when she completed the MDS section for behaviors. She was unaware of the shower/ bath refusals. On 08/25/2016at 3:18PM, an interview was conducted with the Administrator who stated she expected the MDS to be accurate and complete per the clinical record. F 279 483.20(d), 483.20(k)(1) DEVELOP F 279 SS=D A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	documented " resis #103 refused care. On 8/25/2016 at 3: conducted with the she reviewed the moment of the completed the MDS was unaware of the MDS was unaware of the MDS was unaware of the MDS per the clinical recorded with the expected the MDS per the clinical recorded with the expected the MDS per the clinical recorded with the expected the MDS per the clinical recorded with the expected the MDS per the clinical recorded with the expected the MDS per the clinical recorded with the expected the MDS per the clinical recorded with the expected the MDS per the clinical recorded with the expected the MDS per the clinical recorded with the expected the MDS per the clinical recorded with the to develop, review a comprehensive plant for each resided objectives and time medical, nursing, an needs that are identificated with the psychosocial well-best psychosocial we

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
			A. BOILDI			С	
		345529	B. WING			08/25/2016	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH			201 CLARKS FORK DRIVE ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	by: Based on resident in medical record review develop a plan of car address the care and hospice for 1 of 5 res unnecessary medical findings included: Resident #1 was initia 3/3/15 and readmitted with multiple diagnos renal disease, respiral chronic obstructive planxiety. A nursing note dated #1 was followed by has	terview, staff interview, and w, the facility failed to e with measurable goals to treatment related to idents reviewed for tions (Resident #1). The ally admitted to the facility on d to the facility on 7/22/16 es that included end stage atory failure, heart failure, ulmonary disease, and 7/22/16 indicated Resident ospice care. Cal record revealed hospice 17/22/16 through 8/23/16 for the most recently updated on ed a care plan for hospice. 8/13/16 indicated Resident	F	279	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged the correctness of the conclusions set forth on the statement of deficiencies. It plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of lift. Corrective action will be accomplished the resident found to have been affected by the deficient practice: Resident #1 had care plan updated on 8/24/2016, to reflect antidepressant medications and associated hospice cath is was completed by MDS nurse #1. Corrective action will be accomplished those residents having potential to be affected by the same deficient practice. Effective 09/19/2016, the Regional Clin Director revised Admission/Readmission communication form to include a section for pre-admission screening. 100% audit for all residents receiving hospice services and who are followed the Program of All- Inclusive Care for the Elderly (PACE) completed by the Direct of Social S	tte I or The Int I e for I d I by I by I by I by I be I tor	
	An interview with Res	sident #1 was conducted on			of Social Services, & MDS nurse #1 an MDS nurse #2 on 9/16/2016. This audi		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C
NAME OF DE	ROVIDER OR SUPPLIER	040023		STREET ADDRESS, CITY, STATE, ZIP CODE	•	8/25/2016
NAME OF F	NOVIDER OR SUFFLIER			, , , ,	•	
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE		
				RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE
F 279	F 279 Continued From page 29		F 27	9		
	8/23/16 at 4:45 PM.	Resident #1 revealed she		focus was on ensuring each re	sident who	
	had received hospice			receives Hospice services has		
	admission through pr			date care plan in place.		
		(0. = 0. 10).		and one printing printing		
	An interview was con	ducted with the		The audit revealed no other re	sidents	
	Administrator and MD	OS Coordinator on 8/24/16 at		failed to have a hospice plan of	f care in	
	9:50 AM. Both the Ad	dministrator and MDS		place.		
	Coordinator indicated	Resident #1 was not on		·		
	hospice. The hospice	e progress notes, dated		Measures put into place or sys	tematic	
	7/22/16 through 8/23/	/16, for Resident #1 that		changes made to ensure that t	he deficient	
	were located in the ha	ard copy medical record		practice will not re-occur:		
		ne Administrator and MDS				
		ministrator indicated she		Effectively 09/19/2016 The Ad		
	· · · · · · · · · · · · · · · · · · ·	vith the hospice provider to		Director or Business Office Ma	-	
	confirm if Resident #1	1 was on hospice services.		complete pre-admission scree	-	
				residents admitted to the facilit	•	
		ducted with the facility Nurse		followed by the Program of All-		
		dministrator on 8/24/16 at		Care for the Elderly (PACE). T		
	10:45 AM. The facilit	-		screening will identify program		
	indicated the hospice	- Table 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		services received by the reside		
		eived hospice services prior		admission in the community, the		
		itinued to receives services		continue to be rendered at the	•	
	through present (8/24			include but not limited to Hosp		
		ally admitted for a short term		The Admission Director or Bus		
	•	ed she had converted to long		Office Manager will receive sur information by contacting the r		
		sion. He indicated Resident by a community healthcare		agent via phone, fax or E-mail,		
		ated services with the		document her findings on the	, and	
	-	e stated that coordinating		"Admission/Readmission com	munication	
		nity healthcare program was		form"	nameation	
		acility and that may have		101111		
		nfusion with whether or not		Effective 09/19/2016, the admi	ttina nurse	
		eived hospice services. He		will write a Hospice Care order	-	
		breakdown in the system		new admit/readmit indicated or	-	
		rected. He indicated this		"Admission/Readmission comm		
		o care plan for hospice for		form" to have Hospice care, ar		
		cated the MDS Coordinator		care plan for Hospice will be g		
		initiating a care plan for				
	hospice for Resident			Effective 09/19/16, Director of	Nursing,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C 08/25/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	1 00/2		
				5201 CLARKS FORK DR	IVE			
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				(X5) COMPLETION DATE	
F 279	indicated her expect		F 2	Assistant Director nurse will review Monday thru Frid the need to updar Upon findings, ap be updated and corders involving hidentified Hospice documented on "with findings and On 09/16/2016; Fore-educated MDS #2, Director of Scondirector, Director Director, Director Director of nursin manager on how a care plan for an Director of Nursing, and/or Note to the complete 100% of facility care plan of all licensed nurse completed by 09/ nurse not educate be allowed to work Education on the development prohires orientation of licensed nurses. Monitoring Proce Director will revie admission/read	Daily Priority List form action taken. Regional Clinical Direct of nurse #1, MDS nurse and Services, Activities of Nursing and Assisting and Certified Dieta to, and when to, deventy resident in the facility of Supervisor will aducation on the revised evelopment process and the supervisor will action and the supervisor will action on the revised evelopment process and the supervisor will action of the supervisor will action on the supervisor will action on the revisor of the supervisor will action for all new the supervisor will alsurably for all Licensed services or Activities	e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345529	B. WING	B. WING		C 08/25/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE, ZIP CODE	1 00/	23/2010
IINIVEDS:	AL HEALTH CARE/NORT	TH DATEICH		5201 CLAR	RKS FORK DRIVE		
UNIVERSA	AL HEALTH CARE/NORT	n KALEIGH		RALEIGH,	, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page	e 31	F	Hospic and of daily (weekly or until maintal m	e all residents indicated to have fee care have the Hospice order care plan. This audit will be done (Monday thru Friday) x 4 weeks the y x 4 weeks and monthly x 3 more in the pattern of compliance is ained. Ive 09/22/2016, prior to submission of Social Services and/or ties Director will review completed Assessment by MDS Nurse #1 or Nurse #2 to ensure antidepressal eations are care planned when atted. These reviews will take place ay through Friday for 4 weeks on letted MDS assessments, 50% of letted MDS assessments weekly feeks, then 25% of all completed MDS assessments weekly fee	nen nths on, d nt ee all all or os of se ets ion	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C
	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT			STREET ADDRESS 5201 CLARKS FO RALEIGH, NC		08/25/2016
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F 279	Continued From page	÷ 32	F 2	priority list meeting bi office after Director of completion weeks, the Director of facility Qualimprovement	form and filed in clinical nder in Director of Nursing proper follow ups are done. Nursing will review the proper form of priority list weekly x 4 are monthly x 3 months. Nursing will report findings ality Assurance Performance and Committee for any monitoring needs or alterationirement.	to
F 280 SS=D	PARTICIPATE PLANI The resident has the incompetent or otherwincapacitated under the participate in planning changes in care and a comprehensive care within 7 days after the comprehensive assess interdisciplinary team physician, a registere for the resident, and a disciplines as determined, to the extent pratter resident, the resident representative; a change of the comprehensive assessment of the comprehensive assessment of the resident, and a change of the comprehensive assessment of the comprehensive assessmen	right, unless adjudged vise found to be ne laws of the State, to g care and treatment or treatment.	F 2	30		9/22/16
	This REQUIREMENT	is not met as evidenced				

I v /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING		l	C 08/25/2016	
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F 280	Continued From pag	e 33	F 28	0			
	by: Based on observation medical record revise and revise plans of contravenous (IV) fluid nutrition (Resident # residents. The finding of th	on, staff interview, and we the facility failed to review are in the areas of s (Resident #147) and 72) for 2 of 26 sampled ags included: Is admitted to the facility on diagnoses that included pertension, and Im Data Set (MDS) 20/16 indicated Resident intact. She was coded as erapeutic diet and IV feeding S review period. ated 5/20/16 indicated IV 147 due to her experiencing and unable to take in oral		This plan of correction constitute written allegation of compliance. Preparation and submission of the this plan of correction does not compliance an admission or agreement by the provider of the truth of the facts at the correctness of the conclusion forth on the statement of deficient plan of correction is prepared and submitted solely because of requivalent state and federal law, and demonstrate the good faith attem the provider to improve the quality of each resident. F280 Corrective action will be accompliated resident found to have been a by the deficient practice: Resident #147 care plan for intravent (IV) fluid discontinued by the MDS coordinator on 8/25/2016. Resident	is plan of constitute e e lleged or s set cies. The d irement to pts by y of life ished for affected evenous S ent #72		
	A plan of care was initiated on 5/22/16 for Resident #147 that indicated she was at risk for an alteration in fluid volume and required IV fluid due to nausea and vomiting. The interventions included: monitor IV site every shift, administer IV fluids or parenteral nutrition as ordered, obtain			nutrition care plan reviewed and rand "no straw" removed from care 08/25/2016. Corrective action will be accompliathose residents having potential to	e plan on ished for o be		
	symptoms. A physician's order of discontinuation of IV On 8/18/16 the plan	monitor for changes in lated 5/23/16 indicated a fluids for Resident #147.		affected by the same deficient pro- 100% of audit for current resident completed on 09/16/2016, 09/17/ 9/18/2016, by the Director of Nurs Assistant Director of Nursing, MD #1 and MDS nurse #2 to identify	ts 16, and sing, vS nurse any other		
		eviewed by the MDS DS Coordinator documented		residents who have had an order intravenous fluid in the last 12 mg			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345529	B. WING		0	8/25/2016	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COL			
				5201 CLARKS FORK DRIVE			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616			
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F 280	Continued From pag	e 34	F 28	30			
	fluids, "8/18/16 [plan	nard copy care plan for IV of care] reviewed - updated ". The care plan was signed		ensure their care plan is revis	sed as		
	by the MDS Coordin	ator.		The audit revealed that 2 oth had IV fluids ordered in the la	ast twelve		
		esident #147 on 8/22/16 at outlization of IV fluids.		months but did not have a ca the IV fluids.	re plan for		
	An interview was con Administrator on 8/2	nducted with the 4/16 at 5:39 PM. She		100% audit of current resider on 09/16/2016, 09/17/16 and	•		
		ation was for care plans to be d based on the resident's		by the Director of Nursing, As Director of Nursing, MDS nur			
	medical record.			MDS nurse #2 to identify any residents with adaptive eating			
		nducted with Nurse #1 on Nurse #1 stated she had		and/or any restrictions of not	using straw		
	indicated she was fa She stated Resident	for about a month. She miliar with Resident #147. #147 had not received IV working at the facility.		The audit revealed 11 other radaptive eating devices that updated on their care plan.			
	Coordinator on 8/25/			Measures put into place or sy changes made to ensure that practice will not re-occur:			
	1	an related to IV fluids for discontinued as of that		The Regional Clinical Directore-educated MDS nurses (#1 Social Services Director, and administrative staff on how to revise and update Care Plan manner. This re-education won 9/19/2016.	& #2), nursing review, in a timely		
	2/12/13 and readmitted diagnoses included:	oreen s admitted to the facility ded on 5/30/16. Cumulative dementia without behavioral phagia (difficulty swallowing).		Moving forward licensed nursexpected to update care plar approaches as changes arise 09/20/2016.	e, effective		
	A Significant Change	e Minimum Data Set (MDS)		Director of Nursing, Assistan Nursing or RN Supervisor will			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED	
		345529	B. WING		C 08/25/2016		
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F 280	Continued From page	e 35	F 2	80			
	dated 6/6/16 indicated Resident #72 was severely impaired in cognition. He required extensive assistance with eating.			100% education on the revised care plan updating process for nurses will be completed by 09 Any Licensed nurse not educat	all licensed 0/22/2016. ted by		
	reviewed and revised	an dated 6/6/16 and last d 7/14/16 stated Resident		09/22/2016 will not be allowed until educated. Education on th	ne facility		
		tered nutrition secondary to		care plan updating process is a			
	being on a mechanically altered/therapeutic diet with honey thickened liquids. Approaches			the new hires orientation education new licensed nurses. This education			
	included, in part, No	• • • • • • • • • • • • • • • • • • • •		also be provided annually for a nurses.			
	_	was conducted on 8/24/16 at 72 was sitting in the main		nuises.			
	dining room and was			Monitoring Process			
		n and assisted him with his		Director of Nursing, Assistant D			
		sed for his thickened liquids.		nursing, Nursing Supervisor as MDS nurse (#1 & #2), will moni	itor		
		orders was conducted and		compliance of care plan update			
		's dated 6/28/16 that stated		conducting clinical meeting dail	-		
	_	laughter/ responsible party		(Monday-Friday), effective 9/20 meeting covers any change of			
		s. D/C (Discontinue) no		condition that occurred from the			
		have straws with nectar		clinical meeting, review of phys			
		nere was also a physician's		orders written from prior clinica			
	-	hat stated the following:		any admission/discharges occu	•		
	Diet clarification: med	chanical soft, nectar thick		the last clinical meeting and/or	any		
	liquids. May have str	aws.		incidents or accidents occurred prior clinical meeting. The audit			
	On 8/25/16 at 3:19Pf	M, an interview was		discussion will ensure care plan			
	conducted with the M	IDS Coordinator who stated		developed and updated timely.	Findings		
		oonsible for changes to the		from this meeting will be docun			
	•	d she would receive a copy		daily priority list form and filed i			
		ew and revise the care plan		meeting binder in Director of N			
		I the care plan should have		office after proper follow ups ar	e		
	•	ect Resident #72 no longer		completed.			
	needed straws.			Director of pursing will review #	ho		
	On 9/25/16 at 2:200	M. an interview was		Director of nursing will review the			
	On 8/25/16 at 3:20P	dministrator who stated she		completion of priority list weekly weeks, then monthly x 3 month	-		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			1	C 25/2016	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	23/2010	
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	0.11.11.15.7.05	TATELLE OF DEFICIENCIES			ALEIGH, NC 27616 PROVIDER'S PLAN OF CORRECTION			
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F 280	Continued From pag	F2	280					
	expected the care pla	an to be accurate, reviewed n the resident's medical			of Nursing will report findings to facility Quality Assurance Performance improvement Committee for any additional monitoring needs or alteration of this requirement.			
F 309 SS=D	483.25 PROVIDE CA HIGHEST WELL BE	ARE/SERVICES FOR ING	F	309			9/22/16	
	provide the necessar or maintain the higher mental, and psychos	eceive and the facility must ry care and services to attain est practicable physical, ocial well-being, in comprehensive assessment						
	by: Based on staff interview, observation facility failed to have between the facility a failed to have a hospice provider at the residents reviewed for #155). The findings Resident #155 was a cumulative diagnose hypertension and color was admitted to hospice was admitted to hospice was admitted to hospice services inclinately interventions: assist coordinate care with management, and printerview of the care with management, and printerview.	admitted 10/1/15 and had s including dementia, intractures. Resident #155 bice services on 10/28/15. Plan updated 6/24/16 in of care for continuation of uded the following with set up of hospice,			This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plathis plan of correction does not constituan admission or agreement by the provider of the truth of the facts alleged the correctness of the conclusions set forth on the statement of deficiencies. plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of lift of each resident. Corrective action accomplished for the residents found to have been affected the alleged deficient practice:	ute d or The ent y fe		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 309	Continued From page	e 37	F3	309			
	hospice progress not Provider but there wa	Record revealed there were es from the Hospice as not a hospice care plan, vider, in Resident #155 's			Resident #155 Hospice care plan retrieved from the Hospice company or 9/14/2016 by the director of social services and filed in resident's medical records.		
	during medication padispense a medication pack stored in the comedication lock box a pack to the lock box of the blister pack she of from could be observed pack and confirmed to dispensed was Loraz anxiety) 1 mg (millign Nurse #5 indicated the Lorazepam must be a medication for Reside had been wanting to her scheduled dose of (antianxiety medicatic controlled drug lock to unable to locate Xanathen indicated she ne sort out the discrepans	tepam (a medication for fam). Upon confirming this, that she thought the family provided in			Resident #155 order for Lorazepam 1 r discontinued by facility physician on 8/25/2016 and. Order for Xanax 0.25m by mouth three times daily received on 8/25/2016. Resident #155 medications reviewed a reconciled by hospice nurse and the Director of Nursing on 09/19/2016 to ensure accuracy. Corrective action will be accomplished those residents having potential to be affected by the same alleged deficient practice: 100% audit for all hospice residents completed by the Medical Record personnel, on 09/19/2016 to identify ar other residents with no hospice care pl in active records, findings documented "Hospice record audit form" and discrepancies addressed immediately l contacting the hospice company.	g nd for on	
	and stated that she concentrated Resident and was too sent a prescription to #155 to have Lorazed the pharmacy sent to after she talked to the the prescription from Nurse #5 indicated the	alled the pharmacy for the d that the hospice physician the pharmacy for Resident pam 1 mg so that was what the facility. She added that e pharmacy they faxed her the hospice physician.			The audit revealed that all other hospic residents had a hospice care plan. Medication review for each hospice resident will be completed by the Hosp nurses on 09/16/2016, 09/19/2016 and 09/20/2016 to ensure each resident medication profile matches between the	ice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 309	F 309 Continued From page 38		F 3	809				
	provider because the informed the facility of	hospice provider had not of the order change and			facility records and Hospice medical records.			
	therefore the facility did not have an order to give Resident #155 Lorazepam 1 mg. Nurse #5 stated that since she now had a copy of the prescription from the hospice physician she was				Medication review for each hospice resident revealed that all hospice residents medications were up-to-date.			
		ty physician to get a new			·			
		55 to have the Lorazepam 1			Measures put into place to ensure that			
	mg scheduled, instea	ad of the Xanax 0.25 mg.			alleged deficient practice will not recur:			
	On 8/25/16 at 9:16 AM the Hospice Nurse (HN #1) listed in the resident 's medical record was				Moving forward all hospice care plans be filed within one week of residents			
		d. She stated that she had			admission to hospice in each resident	S		
		are for Resident #155 about ther hospice nurse and did			active medical record. Effective 09/19/2016			
	_	t the situation. She indicated			03/19/2010			
		re the facility had not been			Administrator, Director of Nursing, and	the		
		cation change and was not			Director of Social Services together with			
	sure of the particulars	•			the Regional Clinical Director met with			
	-	ged. She thought perhaps			Hospice team to include Hospice nurse	ا ,		
	the hospice physiciar	n's nurse had sent the			Hospice Social worker and Hospice			
	prescription to the ph	armacy but that she (HN #1)			Liaison for 1 of 3 companies that provi	de		
	had not been aware	of it so could not call in a			care and services in the facility on			
		cility. HN #1 stated she had			09/14/2016 to discuss best practices o	ก		
	_	see the resident once and			collaboration of care between the facili	ty		
		the facility but did not know			and the Hospice Company.			
		care plan was not in the						
		ecord at the facility but said			Administrator, Director of Nursing, and			
		py for the residents Medical			Director of Social Services will meet wi	th		
	Record at the facility.				the other two companies no later than			
	0 0/05/40 40.00				09/22/2016 to discuss best practices o			
		M Nurse #5 stated that the			collaboration of care between the facili	-		
	facility physician state				and the Hospice Company. This meeting	ng		
		zepam 1 mg for Resident			will be led by the facility Administrator.	ĺ		
	•	n the scheduled Xanax 0.25			,, , , , , , , , , , , , , , , , , ,	ĺ		
		since she did not currently			Hospice admission communication for			
		scheduled Xanax she was			created on 09/19/2016 by the Regiona	l l		
		macy to have it sent from			Clinical Director. This communication	ĺ		
	the pharmacy back u	p to obtain it quickly.			form will be completed by the admitting	, !		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	LTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING	B. WING			25/2016
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	interviewed and state	M the Administrator was ed that she expected the oordinate care with the	F3	hospice of communication and Director of Social Second Sec	all the Admission Director, a office manager, Director of prvices, MDS nurse # 1 and M and provided to the facility under Hospice when a resident elect to be understood to the facility under Hospice when a resident elect to be understood to the facility under Hospice when a resident elect to be understood to the facility under Hospice when a resident elect to be understood to the facility under Hospice when a resident elect to be understood of all licensed nursing include full time, part time and and nursing staff, will be completed to the facility in the facility of the provides. This educated will focus on the facility is endoubled to the facility is endoubled to get in touch with the hospical to get in touch with the hospical records.	ed ext DS nt edder our eted us	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _		08/5	25/2016	
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	daily living receives the maintain good nutrition and oral hygiene. This REQUIREMENT by: Based on staff interv	RE PROVIDED FOR ENTS ble to carry out activities of the necessary services to on, grooming, and personal is not met as evidenced iew, resident interview,		This education will be completed by 09/21/2016, any licensed nurse not educated by 09/21/2016 will not be allowed to work until educated. Monitoring Process; Director of social services or Medical Record Personnel will audit each hosp resident's health record daily (Monday through Friday) x 4 weeks to ensure Hospice care plans are in place. Director of nursing or Assistant Director Nursing will audit each hospice resident medication profile once a week x4 weethen monthly x 3 months or until the pattern of compliance is maintained. Findings of this monitoring process will reported to the facility quality assurance and Performance improvement commit by the Director of nursing or Director of Social services member for further monitoring needs or changes of the plantage.	or of ont's eks I be se ttee f	9/22/16	
	observation and reco	rd review the facility failed to		written allegation of compliance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING		C 08/25/2016	
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F 312	F 312 Continued From page 41		F 31	2		
F 312	shave a male resident daily living care to 1 or reviewed for activities 22). The findings incomplete the first state of the care of the ca	t while providing activities of a sampled male residents of daily living (Resident # uded: mitted 8/14/14 with a including diabetes, aritis and glaucoma. mum Data Set (MDS) a assessment indicated the rely cognitively impaired and sistance of one person for an dated 6/14/16 revealed a ries of daily living with an ated the resident required a activities of daily living. M an attempt was made to the required and the resident required a receiving patient care to that	F 31	Preparation and submission of this plan of correction does not const an admission or agreement by the provider of the truth of the facts alleg the correctness of the conclusions se forth on the statement of deficiencies plan of correction is prepared and submitted solely because of requirem under state and federal law, and to demonstrate the good faith attempts the provider to improve the quality of of each resident. Corrective Action will be accomplished the resident found to have been affect by the deficient practice: Resident #22 was shaved on 09/19/2 by assigned nursing assistant. Corrective action will be accomplished those residents having potential to be affected by the same deficient practice. All resident have potential to be affected.	ed or t The ent by life d for ted d for ee:	
	to have facial hair stu one day of growth or stated he was aware and said that he prefe added that staff typica him but that sometime On 6/23/16 at 4:44 M	neelchair. He was observed bble that appeared to be greater. Resident #22 of his unshaven facial hair erred to be shaved daily. He ally did not offer to shave es he would ask.		100% choices and preferences audit completed by the Director of Social Services on 09/15/2016 & 09/16/2010 determine each residents choices an preferences, specifically in relation to walking. Non-interview able resident choices and preferences were done interviewing power of attorney and or guardian. Findings of this audit are documented on "Resident Choices A	d s by	
	up in his wheelchair in have facial hair stubb	n his room. He continued to le on observation.		tool". At the time of the audit, all shaving w	as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH			201 CLARKS FORK DRIVE			
					ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 312	Continued From pag	ue 42	F3	312				
	On 8/25/16 at 9:09 A	M Resident #22 was			current.			
		heelchair and dressed for the						
	-	w he indicated that staff were			100% grooming audit completed by			
		s showers on Mondays and			Restorative aides on all residents to			
	Thursdays but were	not shaving him daily. He			identify any other resident who may be			
		been shaved yet this week			require shaving. This audit was comple			
	· •	shaved daily. He was			on 09/16/16, 09/17/16 and 09/18/16. A	ny		
	the facial hair observ	cial stubble consistent with			findings will be addressed promptly.			
	the facial fiall observ	7dtio11 011 0/20/10.			Measures put in place or systematic			
	On 8/25/16 at 1:52 F	PM Nursing Assistant #5 was			changes made to sure that the deficier	ıt		
		dicated that if residents had			practice will not re-occur:			
	facial hair that was n	oticeable she would offer to						
	shave them She als	o stated that she had told			Effective 9/22/16, Resident choices and	d		
		that morning that she would			preferences to include choices for shave	/ing		
		ad not had time to do it as			will be assessed on			
	yet.				admission/readmission, quarterly and v	vith		
	On 9/25/16 at 2:20 F	PM the Administrator was			significant changes on "Choices and Preference tool" by Director of Social			
		dicated that it was her			Services or Activities Director. Any			
		sident with visible facial hair			choices and preferences identified by t	he		
	be shaved daily if the	ey wanted to be shaved daily. she was aware Resident #22			tool will be implemented as indicated.			
	liked to be well groon	med and added that his			Effective 09/20/2016, Resident choices	3		
	family came in at lea	st weekly to cut his hair and			and preferences, specifically for shaving	ıg		
	shave him.				will be added on nursing assistants car	e		
					cards to ensure nursing assistants are	<i>:</i>		
					aware of each resident's shaving			
					preferences. Shaving preferences on			
					CNA care card will be updated based of	n		
					Choices and preferences assessment completed by the Director of social			
					services or Activities Director, informat	ion		
					shared by a resident or family member			
					observation made by licensed nurses a			
					administrative staff that may warrant			
					changes on shaving frequency.			
					Effective 09/19/2016, resident's license	ed		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C 25/2016
	ROVIDER OR SUPPLIER AL HEALTH CARE/NOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616	1 06/	25/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PF REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 312	Continued From pag	e 43	F 31	nurse or certified nursing assistant expected to identify resident needs shaving during their shift and offer assistance for shaving as appropria Any refusal will be documented in resident's records. Effective 09/19/2016, Resident grostatus specifically, shaving, is adde the Ambassador rounds worksheet will aid identification of shaving need a timely manner. Ambassador rour conducted by the facility administratif to specific assigned room dail (Monday thru Friday). Ambassador findings, specifically shaving needs be communicated in a stand up medaily for follow ups. 100% residents rights, to include coand preferences education of all st departments, to include full time, pand as needed staff, will be completed be 09/22/2016, any current staff not education will be completed be 09/22/2016, any current staff not education be allowed to we completed. This education is also provided for all new hires during the orientation process and will be domainually. 100% education for all licensed nustaff and nursing assistants, to include resident's preferences for shaving, as how to identify resident who needs to denote the preferences for shaving, as how to identify resident who needs to denote the preferences for shaving, as how to identify resident who needs to denote the preferences for shaving, as how to identify resident who needs to denote the preferences for shaving, as how to identify resident who needs to denote the preferences for shaving, as how to identify resident who needs to denote the preferences for shaving, as how to identify resident who needs to denote the preferences for shaving, as how to identify resident who needs to denote the preferences for shaving, as how to identify resident who needs to denote the preferences for shaving, as how to identify resident who needs to denote the preferences for shaving, as how to identify resident who needs to denote the preferences for shaving.	s for ate. soming ed on t. This eds on onds are ative yy r rounds s, will eeting shoices eaff, all eart time eted by Director rvices. yy ducated ork until e one rsing lude full f, on entify as well	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C 08/25/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>		
UNIVERS	AL HEALTH CARE/NORT	'H RAI FIGH		5201 CLARKS FORK DRIVE			
ONIVERO	AE HEAETH GARE/NORT	MALLION		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD I			(X5) COMPLETION DATE
F 312	Continued From page	e 44	F3	shaving, and the facility expect how to care for dependent resirelates to shaving will be completed by Osy/22/2016, any nursing. This education will completed by Osy/22/2016, any nursing staff not educated by 9 not be allowed to work until edu. This education will be also be for all new hires during orientat process and will be done annueffective Osy/22/2016. Monitoring Process: Resident Appointed Ambassadd Administrative staff) will comple rounds daily (Monday thru Frida assigned residents to ensure a care and services are rendered shaving. Although, Ambassado and rounds will continue to take part of the facility Quality Assur Performance Improvement progented the documentation of shaving of by resident's assigned ambass take place daily (Monday thru Fweeks, weekly x4 weeks and the monthly for three months or unit pattern of compliance is maintal Administrator, Director of Nursing weeksnut to ensure nursing stameeting needs of dependent resinvolving shaving. These round completed once a day for 2 weeksnut weeks, weeks then monthly x 3 months	dents as bleted by nt Director be current 0/22/16 w ucated. e provided tion ually, lors (Facilitate) to the propriate of to include propriate of the propriate	lity ng eir ede m s d t ce	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616			25/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page	e 45	f 5	312	the pattern of compliance is maintained. The Director of Nursing will report finding of walking rounds to Quality Assurance and Performance Improvement. Committee monthly for three months of until pattern of compliance is obtained.	ngs	
F 329 SS=D	Each resident's drug unnecessary drugs. A drug when used in extendible duplicate therapy); or without adequate more indications for its use adverse consequences should be reduced or combinations of the resident, the facility may be a drugs under these drugs under the dr	regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate ; or in the presence of es which indicate the dose discontinued; or any easons above. ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic I dose reductions, and	F3	329			9/22/16
	This REQUIREMENT by:	is not met as evidenced					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED
		345529	B. WING		0.5	C 3/ 25/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5/25/2010
				5201 CLARKS FORK DRIVE		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616		
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F 329	Continued From pag	e 46	F 32	9		
	interview, the facility laboratory work for H hemoglobin), keppra of five residents reviewed residents reviewed residents. Lexi-Comp 12th edit handbook indicated, fasting lipid panel and recommended for re	ecord review and staff failed to obtain ordered lgbA1C (glycosylated level and lipid panel for one ewed for unnecessary ident #136). The findings ion of the Geriatric Dosage in part, monitoring of the d blood glucose/ HgbA1C is sidents who receive atment, at three months and		This plan of correction constit written allegation of compliance Preparation and submission of this plan of correction does not an admission or agreement by provider of the truth of the fact the correctness of the conclust forth on the statement of deficing plan of correction is prepared submitted solely because of resunder state and federal law, a demonstrate the good faith attemprovider to improve the quof each resident.	te. If this plan of our constitute of the test alleged or sions set siencies. The and equirement out to tempts by	
	Resident #136 was admitted to the facility 3/12/15. Cumulative diagnoses included: dementia without behavioral disturbance, hypertension, hyperlipidemia (elevated cholesterol and triglyceride levels) and seizure disorder. A Quarterly Minimum Data Set (MDS) dated 7/21/16 indicated Resident #136 was severely impaired in cognition. Active diagnoses included, in part, hypertension, hyperlipidemia, non-Alzheimer's dementia, psychotic disorder and seizure disorder. A care plan dated 2/18/16 and last reviewed 7/14/16 stated Resident #136 was at risk for side effects from antipsychotic and antidepressant drug use. Approaches included, in part, Obtain lab work as ordered by the physician and report results when available. A review of physician's orders for August 2016 revealed Resident #136 received the following medications: Keppra (seizure medication) 500			F329 Corrective Action will be according the resident found to have been by the deficient practice: Resident #136 laboratory world HbA1C (glycosylated hemoglot Keppra level and Lipid Panel of 08/24/16 by the contracted licitation and filed in resident's marecords.	k to include bbin), obtained on censed mmunicated	
				Corrective action will be accor those residents having potenti affected by the same deficient All residents have potential to 100% audit for all ordered labs since 08/01/2016 will be comp Director of Nursing and Assist of Nursing on 9/19/2016, 09/2	ial to be practice: be affected. oratory tests bleted by the ant Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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				52	201 CLARKS FORK DRIVE		
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F 329	F 329 Continued From page 47		F3	329			
F 329	milligrams by mouth of Seroquel (antipsychology mouth twice daily (medication used for milligrams by mouth of A review of physician revealed Resident #1 laboratory orders: lipil levels q 6 months. A review of the medic revealed the last lipid 10/7/16. There was not help the last lipid 10/7/16 at 12:30F conducted with the Adwere unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwere unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwere unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwere unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwere unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find a HgbA1C, keppra or lipid 10/5/16 at 12:30F conducted with the Adwerence unable to find 10/5/16 at 12:30F conducted with the Adwerence unable to find 10/5/16 at 12:30F conducted with the Adwerence unable to find 10/5/16 at 12:30F conducted with the Adwerence unable to find 10/5/16 at 12:30F conducted wi	twice daily for seizures, tic medication) 25 milligrams for psychosis and Pravachol hyperlipidemia) 20 every evening. 's orders for August 2016 36 had the following ds, HgbA1C and keppra cal record for Resident #136 panel was obtained on no record of results for the ra level. PM, an interview was dministrator who stated they ny laboratory results for the pids. She stated she to follow physician orders		329	09/21/2016 to identify any other laboratest ordered but not obtained. Any laboratory test ordered but not obtained will be obtained promptly, and physicia will be notified. Findings of this audit we be documented on the "Daily Lab audiform". 100% audit for all ordered laboratory routine laboratory tests for current residents will be completed by the Dire of Nursing and Assistant Director of Nursing on 9/19/2016, 09/20/2016 & 09/21/2016 to identify any other laboratest ordered but not obtained. Any rout laboratory test ordered but not obtained will be obtained promptly, and physicia will be notified. Findings of this audit we documented on the "Daily Lab audiform". Measures put in place or systematic changes made to ensure that the deficit practice will not re-occur: Effective 09/19/2016, a new laboratory process implemented in the facility. This process will ensure all ordered laboratory tests are transcribed, obtained, and results reported to resident's attending physician in a timely manner. This lab process will involve three steps approate to ensure compliance. The first step will be completed by a licensed nurse responsible to care for the resident (nurse on duty). Nurse on duty will transcribe any ordered laboratory to both the facility electronic medical	d n n n n n n n n n tory ine d n n n n ill t	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345529	B. WING			00/	25/2016
	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616			29/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CO	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page	e 48	F3	records and the system effective. The second stellicensed nurse resident during Night shift nurs chart check and include laborate appropriately. I' not transcribed nurse will ensu Laboratory test licensed laboratory test licensed laboratordered to be be returned to be returned to and/or electron. The third step will be resordered laborated to be communicated Evening shift me laboratory log from the second to be results. Evening gatekeepers of the third step will be results. Evening gatekeepers of the third step will be results. Evening gatekeepers of the third step will be results are ordered also follow up to the second step of the system.	ep will be completed by a responsible to care for the night (Night shift nurse) are will complete a 24 hours of ending the will complete a 24 hours of ensure all orders to ory tests were transcribed from any laboratory test was as ordered, night shift are it is transcribed. Its will be obtained by the atory vender on the date completed and results with the facility via facsimile stream of the will involve the nurse on ening shift, Effective energy evening shift nurse on a complete to ensure all tory tests are resulted any to MD in a timely manner urse will indicate on a date of the will shifts are responsible to the proposible of the will shifts are responsible to the proposition of the will shifts are responsible to the laboratory of shift nurses are the	the). urs ed s eill nd er. ailly t at to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREE	FADDRESS, CITY, STATE, ZIP CODE	1 00/	23/2010	
				5201 C	LARKS FORK DRIVE			
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		RALEI	GH, NC 27616			
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F 329	Continued From page	ge 49	FS	Reiming for number of for partials continued to the conti	mpleted and results obtained. We standing orders lab protocol plemented in the facility effective /19/2016. This laboratory protocol will used to identify type of laboratory tecommended with different therapeutic edication classes to ensure adequate onitoring. When a resident is admitted will initiate a Lab Log Sheet with earth listed. If the resident calls for a landing order lab it will be marked on propriate month. At the beginning of the month, the Director of Nursing, sistant Director of Nursing and/or ursing manager will review these Lab of Sheets and entere them into the extronic lab system to be drawn. In will be maintained by the Director resing or designated staff who will be sponsible to track all standing order poratory tests in the facility. In 09/14/2016, Regional clinical direct mpleted an education to the Director resing, Assistant Director of Nursing and Clerk on new laborator occass in the facility. In 09/14/2016, Regional clinical direct mpleted an education to the Director resing, Assistant Director of Nursing and Clerk on new laborator occass in the facility. In 09/14/2016, Regional clinical direct mpleted an education to the Director resing, Assistant Director of Nursing and Clerk on new laborator occass in the facility. In 109/14/2016, Regional clinical direct must be decented by 09/22/2016. Any licensed as not educated by 09/22/2016. Any licensed rese not educated by 09/22/2016 will	ests c e e d the f or of and ry tor one, ew be d		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	JST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE	
F 329	Continued From pag	e 50	F	329	be allowed to work until educated. The new laboratory process will be add to new hire orientation process for all licensed nurses effectively 09/22/2016, and will also be provided annually. Monitoring Process: Effective 09/19/2016; Director of Nursin Assistant Director of Nursing and/or Nursing Manager will review physician orders for the prior day, for proper transcription and follow through. Director Nursing, Assistant Director of Nursin Nursing supervisor will follow up to ensany laboratory tests noted were obtained as ordered. This monitoring will be don daily (Monday - Friday) x 4 weeks, Week x 4 weeks then monthly x 3 months or until the pattern of compliance is maintained. The review of the lab order compared to the physician orders will be kept together in the Director of Nursing office as a monitor tool. Effective 09/19/2016; Medical record Clerk will review laboratory log for the prior day(s) and compare with laborato tests obtained on that date, to ensure a ordered laboratory tests were complete resulted and followed through appropriately. Any discrepancies noted will be reported to the Director of nursing and/or the Administrator. This monitoring will be done daily (Monday - Friday) x 4 weeks, Weekly x 4 weeks then monthly 3 months or until the pattern of compliance is maintained.	r oe l ry all ed, l ng ng 1	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD	
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UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616	
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F 329	Continued From page	e 51	F3	Director of Nursing will report facility Quality Assurance Per improvement Committee for a cadditional manitaring people of	rformance any
F 353 SS=D	483.30(a) SUFFICIEI PER CARE PLANS	NT 24-HR NURSING STAFF	F3	additional monitoring needs of this requirement.	9/22/16
	provide nursing and r maintain the highest				
	numbers of each of the personnel on a 24-ho	vide services by sufficient ne following types of our basis to provide nursing n accordance with resident			
		under paragraph (c) of this ses and other nursing			
	section, the facility m	under paragraph (c) of this ust designate a licensed harge nurse on each tour of			
	by: Based on record rev family and resident in provide sufficient num	iew, observation and staff, aterviews, the facility failed to onber of direct care nursing ds of residents as evidenced		This plan of correction const written allegation of complian Preparation and submission of this plan of correction does not be a submission of correction does on the submission of correction does not be submission.	of this plan of

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	` '	E SURVEY IPLETED
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0411.15	CUIMMA DV CI	CATEMENT OF DEFICIENCIES	- 15	<u> </u>	DECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	Continued From pag	e 52	F 35	53		
	by allowing residents	to sit and wait to be fed in		an admission or agreement by	/ the	
	_	oom while other residents		provider of the truth of the fact		
	_	(Residents # 26, # 94 & #		the correctness of the conclus	-	
		idents observed,, failing to		forth on the statement of defic		
		hoice to ambulate daily for 1		plan of correction is prepared		
		ts able to ambulate with		submitted solely because of re		
	assistance (Resident	: # 22), not resolving		under state and federal law, a		
	grievances about res	ident 's getting help in a		demonstrate the good faith att	empts by	
	timely manner, and fa	ailing to shave a male		the provider to improve the qu	ality of life	
	resident while provid	ing activities of daily living		of each resident.		
	care to 1 of 1 sample	ed male residents reviewed				
	for activities of daily I	iving (Resident # 22).		Corrective action will be accor	mplished for	
	The findings included			the resident found to have been	en affected	
	 Cross reference to 	o Tag F 241: Based on		by the deficient practice:		
		vation and interview, the		1. Cross reference to tag F24		
		ents to sit and wait to be fed		Residents are receiving assist	ance with	
	_	room while other residents		meals in a timely manner.		
	_	(Residents # 26, # 94 & #		2. Cross reference to tag F24	-	
		idents observed during a		resident receives ambulation a	assistance	
	lunch meal.			per preference.		
		o Tag F242: Based on staff		3. Cross reference to tag F244		
	· ·	terview and record review		responses and staffing identifi	ed and	
	_	onor a resident 's choice to		resolved.		
	_	of 1 sampled residents able		1.0		
		istance (Resident # 22).		4. Cross reference to tag F312	2: Specified	
		o Tag F244: Based on		resident was shaved.		
		aff and resident interview, the		Compative action will be accer	andiahad fan	
		ve grievances that were		Corrective action will be accor	•	
		nt council meetings promptly. o Tag F312: Based on staff		those residents having potenti affected by the same deficient		
		terview, observation and		All residents have the potentia	-	
		ility failed to shave a male		affected.	II IO DE	
		ing activities of daily living		On 08/30/2016, 08/31/2016 ar	nd	
		ed male residents reviewed		09/01/2016, Regional Clinical		
		iving (Resident # 22).		Director of Nursing and the Ac		
	· ·	PM a family member was		reviewed nursing staffing sche		
		who stated that she felt the		identify and to ensure that suf		
	, , ,	fed and that residents needs		numbers of staff were available		
	_	and timely feeding of meals		nursing care to all residents in	•	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			D MANAGO			(
		345529	B. WING _			08/	25/2016
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	TH RAI FIGH		5	201 CLARKS FORK DRIVE		
ONIVERSA	AL IILALIII CANL/NONI	MALLIGH		R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page were not always beinhaving sufficient staff On 8/25/16 at 10:17 Finterviewed. She staff Restorative Aide that 200 hall that day so the would provide to reside would not be provided she had been pulled. solely assigned to 20 215). Review of the fivere 17 residents on 215) as of 8/22/16. Sassigned to give 3 she was orienting a new sindicated that she felt assignment adequate residents would need carrying out other tas that it felt like they we On 8/25/16 at 2:30 Plinterviewed. She staff working at the facility the facility had been of the previous recertificates the had incorporate previous recertificates the had incorporate previous recertificates the had become awa 2016, before she star Nursing Assistant (NA 1/2 hour period during not formally reassigned Assistants present in Administrator stated to the previous citation of the previous ci	g met by staff due to not PM Nursing Assistant #6 was ted that she was a had been pulled to work on he restorative care she dents while on restorative d to those residents since She indicated that she was 0 hall that day (except Room facility census revealed there 200 hall (excluding room She stated also that she was owers that day and that she staff member. NA #6 t like she was managing the ely but that sometimes to wait while she was ks and that there were days ere short staffed. M the Administrator was ted that she had not been long but that she was aware cited for sufficient staffing on eation survey. She added rated all the citations from eation in to her Quality g program upon starting at inistrator acknowledged that are of an incident in February ted at the facility, where a A) had left the facility for a 2 which her assignment was ed to other Nursing		3353		f seem f seeve	
	with resident 's not h caregiver and staff no	-			The Director of Nursing, Assistant		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345529	B. WING _			C 08/25/2016	
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Administrator indice to ensure this dide. Administrator also of Grievance in respect to they said they work residents about be not being assisted they were suppose grievances regard stated that the received residents who has some walking asseconsidered resolved acknowledged that as expected by the The Administrator	cated that she was taking steps not reoccur in future. The indicated that she was aware gards to timely care, call bells ut staff not coming back like ald, staff complaining to eing short staffed and residents I to walk daily by restorative like ed to be. In regards to the ing walking assistance she cords were reviewed and all the I complained had received istance so the grievance was	F3		egional Clinic ucation for a clude full time taff, in relation ation to inclusive swering call in off call light net. This in the district of the control of	n e e e e e e e e e e e e e e e e e e e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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F 353	Continued From page	e 55	F3	10 inced co 3. 10 the Nu the co be fol app Th Dii sta pa to sta lig un 4. Mo as ree rec app Ree ince as qu	clude choices and preferences flucation involving all staff will be impleted by 9/22/16. Cross reference F244; 10% education of all staff will be done to Director of Social Services, Director arising and Regional Clinical Director arising and Regional Clinical Director arising with receiving concerns to allowing up with a resolution to the appropriate party. The Director of Nursing, Assistant rector of Nursing and Regional Clinical rector will conduct an education for a staff, all departments, to include full time and as needed staff, in relational bell response. Education to include fift responsibilities for answering call that timely and to not turn official light that it residents needs are met. Cross reference F312; bying forward all current nursing asistants will be responsible to honor sident's choices of walking when quested during their shift and as appropriate, effective 09/19/2016. Desident choices and preferences to clude schoices for walking will be sessed on admission/readmission, larterly and with significant changes of hoices and Preference tool".	e by or of on cal all ne, on ude t	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED			
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F 353	Continued From page	e 56	F3	100% education of residinclude choices and prefeducation involving all stompleted. Licensed nurse or certificassistant are expected to needs for shaving during offer assistance for shavappropriate. Resident grooming statushaving, is added on the rounds worksheet. This identification of shaving manner. 100% residents rights edinclude choices and prefeducation of all staff, all include full time, part time staff. 100% education for all listaff and nursing assistatime, part time and as not ADL care specifically on resident's preferences for A flexible orientation schot oaccommodate timely on new employees, to ensutailored to individual quastaff. Monitoring Process Effectively 09/19/2016, A implemented a QAPI momonitor incoming application of Nursing or designed including or designed applicants are poirector of Nursing or designed involved and process of the proces	ferences taff, was ed nursing o identify resident g their shift and ving as us specifically, e Ambassador will aid needs on a timely ducation, to ferences departments, to ne and as needed censed nursing unts, to include ful eeded staff, on how to identify or shaving medule is available on-boarding for ure orientation is alifications of new Administrator has onitoring tool to ations to ensure processed timely.	t y

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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	0.11.41.42.71.07	TEMENT OF RESIDENCES				
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F 353	Continued From page	e 57	F 3	administrative staff will intervier viable applicants within 3 busin application. Compliance with the requirement will be monitored a documented by the facility Human Resources Director or designe (Monday through Friday) for foweekly x 4 weeks then monthly months or until a pattern of commaintained. Effectively 09/19/2016; Directon Nursing, Assistant Director of Nand/or nursing supervisor will residents medical acuity and A care needs daily (Monday through reviewing the resident 24 hound cross-reference daily staffischedule to ensure sufficient not including certified nursing assist licensed nurses, are available allow for provision of nursing caresidents according to their indineeds. The Documentation of the monitoring process will be commonitoring process will be commonitoring process will be commonitoring process will be commonited to include by not limit months or until pattern of committed to include by not limit Director of Nursing, Assistant In Nursing, MDS Nurse # 1, MDS nursing manager, Certified diet manager, Activities Director, Manager will complete w	ness days on is and man e daily ur weeks, y x 3 mpliance is or of Nursing monitor DL direct ugh Friday our report ing ursing staff stants and daily, to are to all lividual care this inpleted dail eeks, y x 3 obliance is the ed to, Director of a Nurse #2, tary ledical rvices, or Business) f, e y

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F 353	Continued From page	e 58	F3	rounds at least once every off shifts and weekends to nursing staff are responsive needs for assistance. "Warmonitoring tool will be use results of these rounds. Will continue every shift x once a day in alternating semore days then, weekly for then monthly for 3 months pattern of compliance is mursing and Administrator current nursing schedule, certified nursing assistance nurses, daily (Monday thromorning team meeting x 4 weekly for 4 weeks and the months, to ensure sufficient are available daily, to allow nursing care for all resident their individual care needs Effectively 09/22/2016 The Nursing will compile a sur all monitoring efforts and proceeding facility Quality Assurance and Performance Improvement monthly for 3 months or uncompliance is evident. 1. Cross reference F241; An assigned facility admininclude at least one of the Administrator, Director of Nursi supervisor, Medical Recordance of the Administrator, Director, Certifie Manager will monitor dining the distribution of the process of the proces	o ensure that we to resident alking rounds do record Valking round 14 days, then shifts for 14 or 4 weeks and or until the naintained. The Director of will review including the and license bugh Friday) weeks, then then monthly font nursing staw for provisions according to the provision of the	ed at or 3 aff nof to	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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F 353	Continued From pag	e 59	F 35	one meal daily to include weekends x weeks, then weekly x 4 weeks and the monthly until substantial compliance is maintained for three consecutive mont. This monitoring is to ensure residents fed timely, one table is served at a time and qualified employees will feed two residents at one time. This monitoring be documented on the 'Dining Monitoriol.' Any negative findings identified during the monitoring process will be corrected promptly. The Director of Nursing will report finding of the dining room monitoring process the Quality Assurance and Performance Improvement Committee monthly for three consecutive months or until a pattern of compliance is achieved. 2. Cross reference F242; Effective on 9/22/16, Activity Director of Administrator will review the completio "Choices and Preference tool" daily (M for 4 weeks, then weekly for 4 weeks at then monthly until substantial compliant is maintained for three months. Effective on 9/22/16, 'resident appointed ambassador' will monitor daily (Mondathrough Friday) to ensure residents choices and preference are implement per "Choices and Preference Tool". A 'resident appointed ambassador' is a department manager who is assigned set of residents to monitor and follow unith that resident as a point of contact. They will document their rounds on the 'Ambassador Round Tool.'	n hs. are e will ing mgs to be ed by ed to a up			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 353 Continued From page 60		F3	353	The Director of Social Services will rep			
					audit findings to the Quality Assurance and Performance Improvement Committee monthly for three months of until a pattern of compliance is achieve	r	
					3. Cross reference F244		
					The Administrator, Department Manage Nursing Supervisor, and/or Manager or Duty will monitor all grievances in relatito call bell responses, staffing or turnin off call bell before care is rendered dail (Monday through Friday) for four weeks weekly for four weeks, then monthly for three months afterwards or until the pattern of compliance is maintained.	n ion g ly s,	
					The Administrator or Director of Social Services will follow-up with resident council president weekly x4 weeks to ensure grievances have been resolved		
					4. Cross reference F312 Resident Appointed Ambassadors (Fac Administrative staff) will complete walk rounds daily (Monday thru Friday) to the assigned residents to ensure appropriations care and services are rendered to inclusive shaving. Although, Ambassador program and rounds will continue to take place apart of the facility Quality Assurance and Performance Improvement program, but the documentation of shaving compliant by resident's assigned ambassador will take place daily (Monday thru Friday) xweeks, weekly x4 weeks and then monthly for three months or until the	ing eir ate ude am as ad ut nce	

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				RALEI	IGH, NC 27616		
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F 353	STORE/PREPARE/SI The facility must - (1) Procure food from considered satisfactor authorities; and (2) Store, prepare, dis under sanitary conditi	CURE, ERVE - SANITARY sources approved or ry by Federal, State or local	F3	Ad As was we me invocor 3x/we the Th of and Co unit	Ittern of compliance is maintained. Iministrator, Director of Nursing and/osistant Director of Nursing will conductalking rounds to include off shifts and exekends to ensure nursing staff are exeting needs of dependent residents volving shaving. These rounds will be impleted once a day for 2 weeks, week for two more weeks, weekly xeeks then monthly x 3 months or until expattern of compliance is maintained and Performance Improvement committee monthly for three months of till pattern of compliance is obtained.	e 4 I d. ngs	9/22/16
	by: Based on observation instructions and staff			wri Pre	nis plan of correction constitutes a itten allegation of compliance. eparation and submission of this plars plan of correction does not constitu		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 371	kitchen was conducted A tour of the walk-in of contained 35 vanilla I supplement) that had dated 7/28/16. The is supplement stated "thawing". On 8/22/16 at 1:00PN stated the nutritional	M, an initial tour of the ed with the Dietary manager. cooler revealed a box that Mighty shakes (nutritional been thawed. The box was instructions on the nutritional Use within 14 days of M, the Dietary manager supplements (Mighty been discarded after 14	F3	an admission or agreem provider of the truth of the correctness of the conforth on the statement of plan of correction is pregsubmitted solely becaus under state and federal demonstrate the good fathe provider to improve of each resident. Corrective Action will be the resident found to have by the deficient practice: On 08/22/2016, certified discarded undated, spoilitems were discarded. Corrective action will be those residents having paffected by the same de All residents have poten On 08/22/2016 Dietary Malk in refrigerator and a for undated, expired, and No other items were four expired, or spoiled. Measures put in place of changes made to ensure practice will not re-occur. On 08/22/2016, the dieta completed 100% educated dietary staff. Education	ne facts alleged onclusions set of deficiencies. To bared and e of requireme law, and to hith attempts by the quality of lift accomplished we been affected dietary managled, and expire accomplished botential to be affect will all storage aread spoiled items and to be undated as that the deficient practice e that the deficient practice ary manager ion with the	for ed. ed. ed. ed, edt,	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION	ON	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER	1 11 1		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616			23/2016
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F 371	Continued From page 63		F3	dating of items, discarding undated, expired, spoiled items, and specific to Mighty Shakes being discarded after 14 days of being thawed from the freezer. To prevent further non-compliance, once items such as Mighty Shakes are pulled from the freezer for use they will be labeled with a thawed date and with a discard date. The dietary staff including cook and aides will be responsible for this process.		ce d	
F 428 SS=D	The drug regimen of reviewed at least onc pharmacist. The pharmacist must	GIMEN REVIEW, REPORT N each resident must be e a month by a licensed report any irregularities to an, and the director of	F 4	The Dieta will check proper da freshness x4 weeks, complianc consecuti The Dieta summary audits to 0 Performar monthly fo	g Process: Iry Manager and or Administration of items, expired items, as of items daily x4 weeks, week, then monthly until substantiate is maintained for two ve months. Iry Manager will report the findings of nutritional shake Quality Assurance and nice Improvement Committee or six months or until a patternice is achieved.	or and ekly al	9/22/16

I` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616	08/23/2016	
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F 428	This REQUIREMENT	e 64 eports must be acted upon. T is not met as evidenced	F 42	8		
	pharmacist interview facility pharmacy con address the need to medications for one cunnecessary medicatindings included: Resident #136 was a 3/12/15. Cumulative dementia without behypertension, hyperli	diagnoses included: navioral disturbance,		This plan of correction constitutes written allegation of compliance. Preparation and submission of this this plan of correction does not co an admission or agreement by the provider of the truth of the facts all the correctness of the conclusions forth on the statement of deficience plan of correction is prepared and submitted solely because of requirements and federal law, and to demonstrate the good faith attempt the provider to improve the quality	s plan of nstitute leged or s set lies. The rement o ots by of life.	
	7/21/16 indicated Re impaired in cognition in part, hypertension, non-Alzheimer's dem seizure disorder. A medical record revi August 2016 reveale the following medicat medication) 500 milling for seizures, Seroque 25 milligrams by mouand Pravachol (medi	iew of physician's orders for d Resident #136 received tions: Keppra (seizure grams by mouth twice daily let (antipsychotic medication) ath twice daily for psychosis		Corrective Action will be accomplis the resident found to have been at by the deficient practice: Resident #136 laboratory work to HbA1C (glycosylated hemoglobin) Keppra level and Lipid Panel obta 08/24/16 by the contracted licens laboratory company, result commut to MD and filed in resident's medic records. Corrective action will be accomplis those residents having potential to affected by the same deficient pra	include include ined on ed unicated cal shed for be ctice:	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 428	Continued From p	age 65	F 42	28			
	revealed Resident laboratory orders: levels q 6 months. A review of the merevealed the last I 10/7/16. There will High High High High High High High High	edical record for Resident #136 ipid panel was obtained on as no record of results for the ppra level. Ally drug regime reviews were rech through July 2016. The ant did not address the need to monitoring for lipids, Keppra or hysic orders. The monthly that the last lipid panel was er 2015. BOPM, an interview was a Administrator who stated they d any laboratory results for the or lipids. She stated she taff to follow physician orders ordered. BSPM, an interview was e pharmacy consultant who 136 was last reviewed on eed a problem had been he last month or so that some of not received their ordered labs. Insultant stated a lost had been ents who needed required labs		100% audit for all ordered la since 08/01/2016 will be con Director of Nursing and Ass of Nursing on 9/19/2016, 09/09/21/2016 to identify any of test ordered but not obtaine laboratory test ordered but will be obtained promptly, a will be notified. Findings of be documented on the "Daiform". 100% audit for all ordered la routine laboratory tests for oresidents will be completed of Nursing and Assistant Dir Nursing on 9/19/2016, 09/20/09/21/2016 to identify any of test ordered but not obtaine laboratory test ordered but will be obtained promptly, a will be notified. Findings of be documented on the "Daiform". Measures put in place or sy changes made to ensure the practice will not re-occur: Effective 09/19/2016, a new process implemented in the process will ensure all order tests are transcribed, obtain	mpleted by the istant Director 1/20/2016 & wher laboratory d. Any not obtained and physician this audit will illy Lab audit aboratory current by the Director rector of 0/2016 & wher laboratory d. Any routine not obtained and physician this audit will illy Lab audit will illy Laboratory in facility. This red laboratory led, and		
	on that list. She s the psychotropic r dose reduction (G	remember if Resident #136 was tated she had been focused on nedications and the gradual DR) for his antidepressant. ust have missed the fact that		results reported to resident's physician in a timely manne process will involve three st to ensure compliance.	er. This lab		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 428	Continued From pag	e 66	F4	128				
Γ 420	the Keppra, HgbA1C obtained as ordered have asked for the late On 8/25/16 at 3:15Pl conducted with the A expected the pharma	and lipids had not been by the physician and should abs to be drawn.	F 2	428	The first step will be completed by a licensed nurse responsible to care for tresident (nurse on duty). Nurse on duty will transcribe any ordered laboratory to both the facility electronic medical records and the electronic laboratory system effective 09/19/16. The second step will be completed by a licensed nurse responsible to care for tresident during night (Night shift nurse). Night shift nurse will complete a 24 hou chart check and ensure all orders to include laboratory tests were transcribed appropriately. If any laboratory test was not transcribed as ordered, night shift nurse will ensure it is transcribed. Laboratory tests will be obtained by the licensed laboratory vender on the date ordered to be completed and results will be returned to the facility via facsimile and/or electronically. The third step will involve the nurse on duty on the evening shift, Effective 09/19/2016, the evening shift nurse on duty will be responsible to ensure all ordered laboratory tests are resulted at communicated to MD in a timely manner Evening shift nurse will indicate on a diaboratory log form when the test result are not back during evening shift on the day. Nurse in all shifts are responsible report laboratory results to physician promptly as they receive the laboratory results. Evening shift nurses are the gatekeepers of this process.	est a he burs ed s iiii		
					The third step will involve the Medical			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _		_	C 08/2	5/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	1 00/20	0/2010
				5201 CLARKS FORK DRIV	/E		
UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)	-	(X5) COMPLETION DATE
F 428	Continued From page	e 67	F4	Records clerk will tests the day after completed, medical follow up to ensure laboratory test on a completed and reside implemented in the 09/19/2016. This labe used to identify recommended with medication classes monitoring. Revised routine lal implemented effect form will be maintanursing, Assistant and/or RN Supervices ponsible to trace laboratory tests in On 09/14/2016, Recompleted an educ Nursing, Assistant Medical Record Cl process in the faci Licensed pharmace 09/20/2016 by the Director on her dut to report and address for monitoring On 09/20/2016 Ph Clinical Services we licensed pharmace.	the prior day were sults obtained. Pers lab protocol er facility effective aboratory protocol with type of laboratory tendifferent therapeuties to ensure adequate boratory tests form trively 09/19/2016. The facility of the Director of Nursing isor who will be the all standing order the facility egional clinical director of Nursing isor who will be the cation to the Director Director of Nursing is erk on new laborator Director of Nursing is erk on new laborator director of Nursing is the need to obtain the prior of the	ill ests c e his of cor and ry	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345529	B. WING			C 08/25/2016	
	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616			25/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	Continued From page	e 68	F 4		medications. Director of nursing and/or Assistant Director of nursing will complete 100% education for all licensed nurses, to include full time, part time and as neede staff, on the new laboratory process. The education will be completed by 09/22/2016. Any licensed nurse not educated by 09/22/2016 will not be allowed to work until educated. The new laboratory process will be add to new hire orientation process for all licensed nurses effectively 09/22/2016, and will also be provided annually. Monitoring Process: Effective 09/19/2016; Director of Nursin Assistant Director of Nursing or RN Supervisor will review physician orders the prior day, for proper transcription ar follow through. Nursing administrative staff will follow up to ensure any labora tests noted is obtained as ordered. This monitoring will be done daily (Monday - Friday) x 4 weeks, Weekly x 4 weeks th monthly x 3 months or until the pattern compliance is maintained. Effective 09/19/2016; Medical record Clerk will review laboratory log for the prior day(s) and compare with laborator tests obtained on that date, to ensure a ordered laboratory tests were complete resulted and followed through appropriately. Any discrepancies noted will be reported to the Director of nursir and/or the Administrator. This monitorir	ed his ded ng, for nd tory s hen of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE COM AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
				_		(С
		345529	B. WING _		 -	08/	25/2016
	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT	TH RALEIGH		52	TREET ADDRESS, CITY, STATE, ZIP CODE 201 CLARKS FORK DRIVE ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliatio records are in order a controlled drugs is ma reconciled. Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the capplicable.	RUG RECORDS, GS & BIOLOGICALS loy or obtain the services of the whole establishes a system and disposition of all all officient detail to enable an an and determines that drug and that an account of all aintained and periodically all officients with currently accepted so and include the yand cautionary		428	will be done daily (Monday - Friday) x 4 weeks, Weekly x 4 weeks then monthly 3 months or until the pattern of compliance is maintained. Effective 09/22/2016; Licensed Pharma will monitor completion of laboratory teneeded for monitoring medication monthly. Reports of past due and due laboratory tests will be generated and reported to the Director of Nursing monthly and addressed promptly. Effectively 09/22/2016; Director of Nurswill report findings of lab audit and monitoring process to the QAPI committee monthly x 3 months or until pattern of compliance is maintained.	y x acy sts sing	9/22/16

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 08/25/2016
	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT	H RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616	00/23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 431	locked compartments controls, and permit of have access to the keep the facility must proving permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when the package drug distribution.	drugs and biologicals in under proper temperature only authorized personnel to eys. ide separately locked, ompartments for storage of	F 43	31	
	by: Based on record revinterview, the facility in medications in 1 (400 medication rooms and (400 medication cart) findings included: 1. On 8/24/16 at 5:10 on the 400/500 hall wrefrigerator, there we Tuberculin Purified Plused to diagnose Tuberculin Plus	PM, the medication room as observed. In the e 2 opened bottles of cotein Derivatives (PPD), erculosis infection, and the other opened bottle		This plan of correction constitutes a written allegation of compliance. Preparation and submission of this pl this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts allegathe correctness of the conclusions seforth on the statement of deficiencies plan of correction is prepared and submitted solely because of requirem under state and federal law, and to demonstrate the good faith attempts the provider to improve the quality of of each resident. Corrective action will be accomplished the resident found to have been affect by the deficient practice: No Residents were named	ed or t The ent by life

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345529	B. WING		C 08/25/2016	
	ROVIDER OR SUPPLIER AL HEALTH CARE/NOP	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616	1 00/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 431	On 8/24/16 at 5:12 PM, Nurse #2 was interviewed. Nurse #2 stated that it was her responsibility to check the medication room including the refrigerator for expired medications. She added that she was told that the medication room had already been checked so she did not check it. On 8/25/16 at 9:30 AM, the Nurse Consultant was interviewed. The Nurse Consultant indicated that PPD should be discarded 30 days after opening per the manufacturer's recommendation. He added that the unit manager (Nurse #2) was responsible in checking the medication room and medication carts for expired and undated medications.		F 43	1. The opened bottles of Tuber Purified Protein Derivatives from 400/500 hall were discarded on 8 2. The bottle of Diltiazem Exter Release and the bottle of Duloxe the 400/500 hall were discarded 8/24/16. 3. The opened foil of Budesoni inhalation from the 400 hall medicart was discarded on 8/24/16. Corrective action will be accompl those residents having potential taffected by the same deficient products of the same deficient p	the 8/24/16. Inded tine from on de cation ished for oo be actice:	
	on 400/500 hall was bottle of Diltiazem E 240 milligrams (mgs 10/16/15, a bottle of drug) 60 mgs with a and a bottle of Lans stomach ulcers) 30 6/28/16. On 8/24/16 at 5:12 interviewed. The nuresponsibility to che expired medications that the medication checked so she did On 8/25/16 at 9:30 interviewed. The N	urse stated that it was her eck the medication room for s. She added that she was told room had already been		On 09/16/16, the Director of Nur Assistant Director of Nursing, Nu supervisor checked all medication rooms and medication carts to er expired medications had been re and that all opened Budesonide i were labeled with an opened date. Measures put into place or system changes made to ensure that the practice will not re-occur: Moving forward, effective 09/20/2 incoming nurse will review the medicart to ensure all open inhalers a when opened. Findings will be re on "short term medication expirat tool". This tool will be maintained Narcotic count book.	rse n storage nsure moved nhalation e. matic deficient 2016, an edication re dated corded ion audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C 8/25/2016	
NAME OF P	ROVIDER OR SUPPLIER	0.0020		STREET ADDRESS, CITY, STATE, ZIP CO	•	0/25/2016	
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH	5201 CLARKS FORK DRIVE				
	T			RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 431	Continued From pag	e 72	F 43	31			
		tion room and medication undated medications.		100% education started with Nurses on 09/17/16 and to b by 9/22/2016. Education incl of expiration dates prior to a	e completed luded review		
	cart was observed. Budesonide inhalatic symptoms of asthma the foil. The opened) observed with 4 vials inside foil had no date of opening.		of medications, and proper of inhalants when opened. Any nurse not educated by 09/22 be allowed to work until education will be updated and the new hire orientation pack	lating of licensed 2/2016 will not cated. This nd added to		
	once the foil/envelop vial/ampule within 2 On 8/24/16 at 5:20 F	16 at 5:20 PM, Nurse #3 was		The Director of Nursing, Ass Director of Nursing, and/or N Supervisor will be responsib checking medication carts at rooms weekly.	lursing le for		
	Budesonide should b	rse stated that the foil of be dated when opened. that the foil was undated.		Monitoring Process:			
	On 8/24/16 at 5:12 PM, Nurse #2 was interviewed. The nurse stated that it was her responsibility to check the medication carts for expired and undated medications. She added that it was her fault for not checking the medication carts. On 8/25/16 at 9:30 AM, the Nurse Consultant was interviewed. The Nurse Consultant indicated that the unit manager (Nurse #2) was responsible in checking the medication room and medication carts for expired/undated medications.			Director of Nursing, Assistar Nursing and/or Nursing Supermonitor the completion of "sl medication expiration tool" of through Friday) x 4 weeks, weeks then monthly x 3 more the pattern of compliance is to ensure that open nurses comply with checking medicate the beginning of their shift are open inhalants are dated, where and that all expired medicate discarded appropriately.	ervisor will hort term aily (Monday veekly x 4 oths or until maintained, on duty ation carts at and ensuring nen opened,		
				Director of Nursing, Assistar Nursing and/or Nursing Sup- check medication carts and rooms, daily (Monday throug	ervisor will medication		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				_		(С
		345529	B. WING			08/	25/2016
	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT	H RALEIGH	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
F 431	COMMITTEE-MEMBI QUARTERLY/PLANS A facility must maintai assurance committee nursing services; a ph facility; and at least 3 facility's staff. The quality assessme committee meets at le issues with respect to and assurance activitidevelops and implem action to correct ident. A State or the Secret disclosure of the reco	in a quality assessment and consisting of the director of hysician designated by the other members of the ent and assurance east quarterly to identify which quality assessment ites are necessary; and ents appropriate plans of iffied quality deficiencies. ary may not require rds of such committee h disclosure is related to the committee with the		520	weeks, weekly x 4 weeks then monthly months or until the pattern of compliance is maintained, to ensure that open Inhalants are dated, when opened, and that all expired medications are discard appropriately. The Director of Nursing will report finding of the medication checks to the Quality Assurance and Performance Improvement Committee monthly for three months or until a pattern of compliance is achieved.	ce d led ngs	9/22/16
		y the committee to identify					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE	
		345529	B. WING			08/2	25/2016
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
IINIVEDS/	AL HEALTH CARE/NORT	TH DAI EIGH		5	201 CLARKS FORK DRIVE		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		F	RALEIGH, NC 27616		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	Ξ	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	DATE
F 520	Continued From page	e 74	F !	520			
		eficiencies will not be used as					
	a basis for sanctions.						
	This REQUIREMENT by:	Γ is not met as evidenced					
	-	ecord review, observation,			This plan of correction constitutes a		
	staff, resident and family interview, the facility's				written allegation of compliance.		
	Quality Assessment and Assurance (QAA)				Preparation and submission of this plan		
	Committee failed to maintain implemented				this plan of correction does not constitu	te	
	procedures and monitor the interventions the committee put into place following the 9/25/14				an admission or agreement by the		
	and 9/17/15 recertification surveys. This was for				provider of the truth of the facts alleged the correctness of the conclusions set	Or	
	the recited deficiencies in the areas of Dignity				forth on the statement of deficiencies.	[he	
		of Daily Living (F312) cited			plan of correction is prepared and	116	
	9/25/14 and 9/17/15				submitted solely because of requireme	nt	
		y (F278), Comprehensive			under state and federal law, and to	.	
		Sufficient Staffing (F353) and			demonstrate the good faith attempts by	,	
		F371) cited 9/17/15. These			the provider to improve the quality of lif		
	-	ed again on the recertification			of each resident.		
	survey of 8/25/16. The	he continued failure of the					
		onsecutive federal surveys of					
	, ,	and two consecutive federal			Corrective action will be accomplished		
	•	278, F280, F353 and F371)			the resident found to have been affected	d	
		e facility's inability to sustain			by the deficient practice:		
	•	Assessment and Assurance			1. Cross reference to tag F241:		
	program. The finding	js included:			Resident #26 is receiving assistan	ce	
	This tax is areas refer	veneed to			with meals in a timely manner.	:4	
	This tag is cross refe				Resident #94 no longer in the facilResident #81 no longer in the facil		
	F241 Dignity: Based				2. Cross reference F278		
		view, the facility allowed			• Resident # 1		
		vait to be fed in the assisted			1a. Minimum Data Set dated 7/29/16 w		
	•	ner residents were being fed			modified/corrected by MDS Nurse #1 o		
	•	i, # 94 & # 81) of 3 sampled			08/24/2016 to indicate in Question J14	JU	
	residents observed d				that resident had life expectancy of 6		
	•	ecertification survey the			months.	100	
		tation for failing to keep a covered and for failing to			1b. Minimum Data Set dated 7/29/16 w modified by MDS Nurse #1 on 08/24/20		

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR MC). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		PLETED
		345529	B. WING				C 25/2016
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				52	201 CLARKS FORK DRIVE		
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH		R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	e 75	F	520			
		eir own clothes appropriate			to indicate in Question O0100 K 1 and	2	
	for the time of day.				modified to indicate resident was	_	
	-	the facility had a F241			receiving Hospice services while not a		
		provide incontinent care			resident and while a resident.		
		to knock before entering a			1c. Minimum Data Set dated 7/29/16 w	as	
	resident 's room.	G			modified/corrected by MDS Nurse #1 o	n	
	F278 Assessment Ac	curacy: Based on resident			08/24/2016 to indicate in Question		
	interview, staff intervi	ew, observation, and			O0100L modified to indicate resident w	as	
	medical record reviev			admitted for respite services while a			
	the Minimum Data Se			resident.			
	accurately in the area			1d. Minimum data Set dated 7/29/16 w			
	(Resident #1), hospic			modified/corrected by MDS Nurse #1 o	n		
	1	ctive diagnoses (Residents			08/24/2016 to indicate in Section I, to		
	-	ions (Residents #11 and			include anxiety as an active diagnosis.		
		ident #103), dental status references for customary			1e. Minimum Data Set dated 7/29/16 w		
	1	(Resident #96) for 5 of 26			modified/corrected by MDS Nurse # 1 0 08/24/2016 to indicate in Question L02		
	sampled residents.	(Nesident #30) for 3 of 20			that resident had no natural teeth.	00,	
		certification survey the			Resident #11		
		ation for failing to accurately			2a. Minimum Data Set dated 7/13/16 w	as	
	code the Minimum Da				modified/corrected by MDS Nurse #1 c		
		ing and Resident Review			09/17/2016 to indicate in question N04		
	and for Pressure Ulce	_			the correct number of days of use of		
	F280 Comprehensive	e Care Plans: Based on			antipsychotic medications in 7 day look		
		erview, and medical record			back period.		
		ed to review and revise plans			2b. Minimum Data Set dated 7/13/16 w		
		f intravenous (IV) fluids			modified/corrected by MDS Nurse #1 of		
	'	nutrition (Resident #72) for 2			09/17/2016 to indicate in Section I, the	:	
	of 26 sampled reside	nts.			correct active diagnosis.Resident #96 is no longer at the		
	During the 9/17/15 re	certification survey the			facility.		
		ation for failing to review and			Resident #72		
		activities of daily living and			4a. Minimum Data Set dated 7/25/16 w	as	
	medications.	·			modified/corrected by MDS Nurse #1 of 09/17/2016 to indicate in question N04		
	F312 Activities of Dai	ly Living Care: Based on			the correct number of days of antibiotic		
		ent interview, observation and			received.		
		ility failed to shave a male			 Resident #103 is no longer at the 		
		ng activities of daily living			facility.		

PRINTED: 10/07/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	<u> </u>		С	
		345529	B. WING			_	
NAME OF D	ROVIDER OR SUPPLIER	040020		STREET ADDRESS, CITY, STATE, ZIP CO		8/25/2016	
NAIVIE OF PI	ROVIDER OR SUPPLIER)DE		
UNIVERSA	AL HEALTH CARE/NO	ORTH RALEIGH		5201 CLARKS FORK DRIVE			
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From page	age 76	F 5	20			
	-	pled male residents reviewed					
		ly living (Resident # 22).		3. Cross reference to tag F2	280		
		recertification survey the		Resident #147 care pla			
		citation for failing to provide		intravenous (IV) fluid discon			
	proper incontinent	· ·		MDS coordinator on 8/25/20	•		
	' '	recertification survey the		#72 nutrition care plan revie			
		citation for failing to provide		revised and "no straw" remo			
	incontinent care to a resident who needed			plan on 08/25/2016.			
		nd for failing to shave a		4. Cross reference to tag F3	312		
	resident.	-		Resident #22 was shave	ed on		
	F353 Sufficient Sta	aff: Based on record review,		09/19/2016 by assigned nur	rsing assistant.		
	observation and st	aff, family and resident		5. Cross reference to tag 35	53:		
		ility failed to provide sufficient		Cross reference to tag			
		are nursing staff to meet the		Specified Residents are rec	-		
		as evidenced by allowing		assistance with meals in a t	-		
		d wait to be fed in the assisted		Cross reference to tag			
	_	other residents were being fed,		Specified resident receives	ambulation		
	,	26, # 94 & # 81) of 3 sampled		assistance per preference.	FO44. Call ball		
		d,, failing to honor a resident 's		Cross reference to tag			
		e daily for 1 of 1 sampled mbulate with assistance		responses and staffing iden resolved.	uneu anu		
		ot resolving grievances about		Cross reference to tag	F312·		
		help in a timely manner, and		Specified resident was shaw			
		nale resident while providing		opcomed resident was snat	.		
		ving care to 1 of 1 sampled		6. Cross reference to tag F3	371		
		iewed for activities of daily		On 08/22/2016, Certifie			
	living (Resident # 2			manager discarded undated	•		
	During the 9/17/15	recertification survey the		expired items were discarde	ed .		
	facility had a citation	on for failing to have an		Corrective action will be acc	complished for		
	assigned Nursing /	Assistant for 7 of 57 residents,		those residents having pote	ntial to be		
		e timely incontinent care and		affected by the same deficie	•		
		sufficient staff to maintain the		All residents have the poten	itial to be		
		nt requiring incontinent care.		affected.			
		nditions: Based on observation,					
		nstructions and staff interview,		1.Cross Reference F241:			
		discard expired nutritional		100% audit of all active resi			
	supplements.	er e		completed on 9/15/2016 by	•		
		recertification survey the		Manager to determine the a			
	tacility had a F371	citation for failing to discard		required during meals and o	ınıng room	1	

Facility ID: 20040007

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			1	25/2016
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F 520	rotten food, failing to for failing to complete during the tray line. An interview was cor Administrator on 8/25 that she had only red Administrator at the falready reviewed the incorporated monitor Quality Assurance (Othat the 8/25/16 defic primarily related to a tag than was cited duthat expanding the for those newly identified repeated deficiencies indicated that as a new she was still working issues that may not he	date food when thawed and ely cover hair with a hair net aducted with the 5/16 at 3:30 PM. She stated ently started as the facility but that she had citations from 9/17/15 and ing in those areas within the DA) Program. She indicated siencies for these citations different aspect of each Furing previous surveys and bous of their QA monitoring in dareas would resolve the	F	520	designation for all three meals. Finding documented on "Dining Designation Autool. 2. Cross Reference F 278: 100% of current residents will be audited by Director of Social Services to determine if they are receiving Hospice Services and Respite Services. The results of the audit indicated that nother residents were hospice or respite services. 1a. 100% of residents on hospice services were audited by MDS Nurse #1 and #2 09/16/2016, 09/17/16 and 09/18/2016 accuracy on Question J1400, Prognosi Modifications/corrections done to Minimum Data Set as indicated per RA guidelines. The results of the audit indicated that a residents currently on hospice were concorrectly under Question J1400. 1b. 100% of residents on hospice service were audited by MDS Nurse #1 and #2 on 09/16/2016, 09/17/16 and 09/18/2016 for accuracy in Question O0100K, Hospice Care while not a resident and while a resident. Modifications/correction done to Minimum Data Set as indicated per RAI guidelines. The results of the audit indicated that a residents currently on hospice were concorrectly under Question O0100K. 1c. 100% audit of residents on respite care were conducted by MDS Nurse #1 and #2 on 09/16/16, 09/17/16, and	ed e e e e e e e e e e e e e e e e e e	

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F 520	Continued From page	÷ 78	F	09/18/16 to ensure that a admitted for respite care of accurately in Question Of Care. Modifications/correspinement of the process of the color of t	were coded 0100L, Respit ctions done to icated per RA audit no on respite care we resident's ment was a #1 and #2 or it 09/18/2016 the were coded Oral/Dental and number of on question secutively per will also include a question E08 done to icated per RA at for Section I ments were 200 revealed in the code of the code	ollower. and old old old old old old old old old ol	

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F 520	Continued From pag	e 79	F	100% of audit for completed on 09/16 9/18/2016, by the Dissistant Director of #1 and MDS nurse residents who have intravenous fluid in ensure their care plappropriately. The audit revealed had IV fluids ordere months but did not the IV fluids. 100% audit of curre on 09/16/2016, 09/16 by the Director of Nursing, MDS nurse #2 to id residents with adap and/or any restriction. The audit revealed adaptive eating devupdated on their care 100% choices and completed by the Diservices and the Act 09/15/2016 & 09/16 each residents choice to include shaving	6/2016, 09/17/16, and prirector of Nursing, MDS nursely to identify any of the hast 12 months, an is revised as that 2 other residented in the last twelve have a care plan for the last twelve at last twelve have a care plan for the l	to ts r eted 6, w had	

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F 520	Continued From pag	e 80	F	100% grooming audit or Restorative aides to ide resident who may be reaudit was completed on 09/17/16 and 09/18/16. be addressed promptly. 5. Cross Reference F35 On 08/30/2016, 08/31/2 09/01/2016, Regional C Director of Nursing and reviewed nursing staffin identify and to ensure the numbers of staff were a nursing care to all reside with residents individual Cross reference F241; dining room designation Cross reference F242; preferences audit comp Director of Social Service residents on restorative re-screened by a License Cross reference F244; resident council minutes months. Cross reference F312; preferences audit comp Director of Social Service grooming audit complete aides. 6. Cross Reference F37 On 08/22/2016 Dietary I walk in refrigerator and for undated, expired, an No other items were four	entify any other equire shaving. The 109/16/16, Any findings will are contained and clinical director, the Administrator of schedule to the hat sufficient entitional providents in accordance of the contained and clinical director, and contained and conta	d d

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F 520	Continued From page	e 81	F 52	expired, or spoiled. Measures put into place or systemic changes made to ensure that the defic practice will not re-occur: On 9/19/2016, Regional Clinical Direct will complete re-training with facility Administrator and The Director of Nursegarding Quality Assurance, Performance Improvement Program (QAPI) process. This education include how to identify quality deficiencies specifically on skin care and wound management program as well as waysestablish system that will ensure consistent, measurable outcomes. The education will also cover methods how to track and trend data, as well as best practices on root cause analysis. administrator and the Director of Nurswill then re-train QAPI committee members on how to properly complete Quality Assurance and Performance Improvement Plan to assure and ensuthe facility sustain an effective Quality Assurance and Performance Improvement plan to prevent repeat non-compliance with Federal and/or Segulations. 1. Cross reference F241; Moving forward, three tables in the madining room will be designated effective 9/19/2016 for residents who requires assistance with feeding. Nursing assistance will be feeding two residen a time, effective 9/12/2016. Trays will delivered to one table at a time effective 9/19/2016.	tor sing, ed s to s on s The ing e the ure state state ts at be			

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F 520	Continued From page	e 82	F	520	100% education of all current nursing staff, to include full-time, part-time and as needed nursing staff, will be comple by Director of Nursing, Assistant Direct of Nursing and/or Nursing supervisor by 9/22/2016. This education will cover facility new dining practices to include; assisting residents on one table at a tin feeding two residents on the same table at one time and ensure all residents are fed in a timely manner. Any nursing stanot educated by 9/22/2016 will not be allowed to work until educated. This education will taught annually and adde to the new hire orientation packet. 2. Cross reference F278: Effectively 09/19/2016 The Admission Director or Business Office Manager with complete pre-admission screening for a residents admitted to the facility and followed by the Program of All- Inclusiv Care for the Elderly (PACE). The screening will identify program and services received by the resident before admission in the community, that will continue to be rendered at the facility to include but not limited to Hospice care. The Admission Director or Business Office Manager will receive such information by contacting the referring agent via phone, fax or E-mail, and document her findings on the "Admission/Readmission communication form" Effective 09/19/2016, the admitting nurwill write a Hospice Care order for any new admit/readmit indicated on the "Admission/Readmission communication form"	eted or y ne, e e nff ed ill all re e	

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F 520	Continued From page	e 83	F 52	form" to have Hospice care, and interir care plan for Hospice will be generated. Effective 09/19/16, Director of Nursing Assistant Director of Nursing and/or M nurse will review physician orders at the Monday thru Friday clinical meeting for the need to update or initiate care plans be updated and or initiated, especially orders involving Hospice Services. Any identified Hospice order will be documented on "Daily Priority List form with findings and action taken. On 09/16/2016; Regional Clinical Director e-educated MDS nurse #1, MDS nurse #2, Director of Social Services, Activitic Director, Director of Nursing and Assist Director of nursing and Certified Dietat manager on how to, and when to, dever a care plan for any resident in the facil Director of Nursing, Assistant Director Nursing, and/or Nursing Supervisor with completed by 09/22/2016. Any License all licensed nurses. This education will completed by 09/22/2016. Any License nurse not educated by 09/22/2016 will be allowed to work until educated. Education on the facility care plan development process is added on new hires orientation education for all new licensed nurses. This education will also be provided annually for all Licensed nurses.	d. DS ne r ns. will for y n" ctor se es stant iry elop ity. of II sed ofor be ed not			

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F 520	Continued From pag	e 84	F 52	The Regional Clinical Director re-educated MDS nurses (#1 & #2), Social Services Director, and nursing administrative staff on how to review revise and update Care Plan in a tim manner. This re-education was cond on 9/19/2016. Moving forward licensed nurses are expected to update care plans with mapproaches as changes arise, effect 09/20/2016. Director of Nursing, Assistant Director Nursing or RN Supervisor will complet 100% education on the revised facilitic care plan updating process for all lice nurses will be completed by 09/22/20 Any Licensed nurse not educated by 09/22/2016 will not be allowed to wo until educated. Education on the faci care plan updating process is added the new hires orientation education for new licensed nurses. This education also be provided annually for all Licenurses. 4. Cross reference F312; Moving forward all current nursing assistants will be responsible to honor resident's choices of walking when requested during their shift and as appropriate, effective 09/19/2016. Resident choices and preferences to include choices for walking will be assessed on admission/readmission quarterly and with significant change "Choices and Preference tool".	ely ucted also new ive or of ete ty ensed 016. rk lity to or all will ensed or			

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F 520	Continued From page	e 85	F 52	100% education of residents rights a include choices and preferences education involving all staff, was completed. Licensed nurse or certified nursing assistant are expected to identify res needs for shaving during their shift a offer assistance for shaving as appropriate. Resident grooming status specificall shaving, is added on the Ambassadd rounds worksheet. This will aid identification of shaving needs on a manner. 100% residents rights education, to include choices and preferences education of all staff, all departments include full time, part time and as ne staff. 100% education for all licensed nurs staff and nursing assistants, to inclutime, part time and as needed staff, ADL care specifically on how to iden resident's preferences for shaving A flexible orientation schedule is avato accommodate timely on-boarding new employees, to ensure orientation tailored to individual qualifications of staff. 5. Cross reference F353 On 08/30/2016, 08/31/2016 and 09/01/2016, Regional Clinical directed Director of Nursing and the Administ reviewed nursing staffing schedule to	sident and sident and sident and sident side	

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 520	Continued From page	e 86	F 5	identify and to ensure that suffice numbers of staff were available nursing care to all residents in a with residents individual care not cross reference F241; 100% and dining room designation. Cross reference F242; 100% of preferences audit completed by Director of Social Services. Cur residents on restorative nursing re-screened by a Licensed The Cross reference F244; 100% at resident council minutes in last months. Cross reference F312; 100% of preferences audit completed by Director of Social Services. 100 grooming audit completed by Director of Social Services. 100 grooming audit completed by R aides. 6. Cross reference F371 On 08/22/2016 Dietary Manage walk in refrigerator and all storator undated, expired, and spoile No other items were found to be expired, or spoiled. Monitoring Process Effectively 09/21/2016; the facil administrator or designated stafmonitor all deficiencies cited in three and track progress to ensfacility sustain an effective qual assurance program to ensure in deficiencies are cited in the future of the progress are cited in the future deficiencies are cited in the future of the progress of the progress are cited in the future of the progress of the progress are cited in the future of the progress of the prog	to provide accordance eeds. udit of noices and of the rent grogram rapist. udit of 12 noices and of the 19% eestorative er checked age areas ed items. e undated, lity ff will the last sure the ity to repeat		

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F 520	Continued From page	÷ 87	F 5.	monitoring will be done monthly x months. 1. Cross reference F241 An assigned facility administrative include at least one of the following Administrator, Director of Nursing, RN supervisor, Medical Records Clerk Activities Director, Certified Dietary Manager will monitor dining rooms one meal daily to include weekend weeks, then weekly x 4 weeks and monthly until substantial compliant maintained for three consecutive in This monitoring is to ensure reside fed timely, one table is served at a and qualified employees will feed to residents at one time. This monitor be documented on the 'Dining Mon Tool.' Any negative findings identified during the monitoring process will corrected promptly. The Director of Nursing will report of the dining room monitoring process will corrected promptly. The Director of Nursing will report of the dining room monitoring process will corrected promptly. 2. Cross reference F278 Effective 09/19/2016, prior to subn Director of Social Services and/or Activities Director will review comp MDS Assessment by MDS Nurse and MDS Nurse #2 to ensure Question Question O0100K, Question O010 Section I, Question LO200, Question I, Question LO200, Question Co200, Question III Review III I Review III Review	staff to g: at least s x 4 then se is nonths. nts are time wo ing will sitoring ed be findings eas to sance or a sission, letted #1 or J1400, OL,		

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F 520	Continued From pag	e 88	F		N0410, and Question E0800 are coded accurately per RAI guidelines. These reviews will take place Monday through Friday for 4 weeks on all completed MI assessments, 50% of all completed MI assessments weekly for 4 weeks, then 25% of all completed MDS assessmen monthly for 3 months or until compliance is achieved. Effective 09/19/2016, prior to submission MDS Nurse #1 and/or MDS Nurse #2 (Whomever is not signing off on the assessment) will review completed MD assessment to ensure question E0800 coded accurately per RAI guidelines. These reviews will take place Monday through Friday for 4 weeks on all completed MDS assessments weekly fa weeks, then 25% of all completed MI assessments monthly for 3 months or until compliance is achieved. MDS nurse #1, MDS nurse #2, Directo Social Services, and or Activities Direct will present the findings of this audit, effective 9/22/2016, to the Quality Assurance and Performance Improvement Committee monthly for three months or until pattern of compliance is achieved. 3. Cross reference F280 Director of Nursing, Assistant Director nursing, Nursing Supervisor as well as MDS nurse (#1 & #2), will monitor compliance of care plan update by conducting clinical meeting daily	on DS DS ts ce on, es is all for DS r of tor	

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F 520	Continued From page	e 89	F 5	(Monday-Friday), effective 9/2 meeting covers any change of condition that occurred from the clinical meeting, review of physorders written from prior clinical any admission/discharges occurred the last clinical meeting and/or incidents or accidents occurred prior clinical meeting. The audidiscussion will ensure care pladeveloped and updated timely from this meeting will be docut daily priority list form and filed meeting binder in Director of Noffice after proper follow ups a completed. Director of nursing will review completion of priority list week weeks, then monthly x 3 monto Director of Nursing will report of facility Quality Assurance Perfimprovement Committee for an additional monitoring needs or of this requirement. 4. Cross Reference F312 Resident Appointed Ambassac Administrative staff) will compliments daily (Monday thru Fridassigned residents to ensure a care and services are rendere shaving. Although, Ambassad and rounds will continue to tak part of the facility Quality Assurance Improvement prothe documentation of shaving by resident's assigned ambass take place daily (Monday thru	f resident ne prior da visician al meeting curred from r any different the dit and ans are v. Findings mented on in clinical Nursing are the different the findings to formance ny r alteration dors (Facil lete walkinday) to the appropriate different to includior program we place as urance and ogram, but compliance sador will	illy I, In Ility Ing Iir Ie Ide In S It	

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F 520	Continued From page	e 90	F	weeks, weekly x4 we monthly for three monthly for the pattern of compliance weekends to ensure meeting needs of depinvolving shaving. The completed once a da 3x/week for two more weeks then monthly for the pattern of compliance of walking rounds to and Performance Implemented and Performance Implemented a QAPI monitor incoming appropriate application. Compliance of Nursing of administrative staff with application of Nursing of administrative staff with application. Compliance of Nursing of American Staff Staf	nths or until the e is maintained. or of Nursing and/on Nursing will conducted off shifts and nursing staff are pendent residents lese rounds will be y for 2 weeks, weekly xox 3 months or until ance is maintained and will report finding Quality Assurance for three months or iance is obtained. 353 6, Administrator homoitoring tool to blications to ensure reprocessed times and staff in 3 business day not with this nonitored and acility Human or designee daily day) for four weeks an monthly x 3 tern of compliance 6; Director of Nurses	act 4 1 1. ngs r as e ely. s of		

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F 520	F 520 Continued From page 91		F 5:	residents medical acuity and ADL direct care needs daily (Monday through Friday) by reviewing the resident 24 hour report and cross-reference daily staffing schedule to ensure sufficient nursing staff, including certified nursing assistants and licensed nurses, are available daily, to allow for provision of nursing care to all residents according to their individual care needs. The Documentation of this monitoring process will be completed daily (Monday through Friday) x 4 weeks,		ff, I		
						weekly x 4 weeks then month months or until pattern of commaintained. Effectively 09/22/2016, one of following to include by not lim Director of Nursing, Assistant Nursing, MDS Nurse # 1, MD nursing manager, Certified diamanager, Activities Director, Necords, Director of Social Se Admissions Coordinator, and/Office Manager will complete rounds at least once every shall contain the complex of the contained on the contained of the contained of the contained on the contained of t	f the ited to, Director of S Nurse #2 etary Medical ervices, for Busines walking ift, to include	s
				off shifts and weekends to enanursing staff are responsive to needs for assistance. "Walking monitoring tool will be used to results of these rounds. Walk will continue every shift x 14 conce a day in alternating shift more days then, weekly for 4 then monthly for 3 months or pattern of compliance is main Effectively 09/20/2016, the Di Nursing and Administrator will current nursing schedule, inclicertified nursing assistance as	o residents or record cing rounds days, then s for 14 weeks and until the tained. rector of I review uding			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	C	(X3) DATE SURVEY COMPLETED		
345529			B. WING			С	
	DOLUBER OF SURELIES	343529		OTDEET ADDRESS OFFI OTHER TIP CODE	<u> </u>	08/25/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH		5201 CLARKS FORK DRIVE			
0.1				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	(X5) COMPLETION DATE		
F 520	Continued From page	92	F 5	nurses, daily (Monday through find morning team meeting x 4 week weekly for 4 weeks and then months, to ensure sufficient nur are available daily, to allow for pursing care for all residents act their individual care needs. Effectively 09/22/2016 The Dire Nursing will compile a summary all monitoring efforts and preserfacility Quality Assurance and Performance Improvement commonthly for 3 months or until at compliance is evident. 6. Cross Reference F371 The Dietary Manager and or Adwill check all nutritional supplem proper dating of items, expired if freshness of items daily x4 weex x4 weeks, then monthly until su compliance is maintained for two consecutive months. The Dietary Manager will report summary findings of nutritional audits to Quality Assurance and Performance Improvement Commonthly for six months or until a compliance is achieved.	cs, then conthly for sing staff provision cording to ctor of y report on to the similar and to the stantial ro the shake in mittee in the shake in	of of or d	